

2023



Class Journal to _____

EXCHANGE

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA.



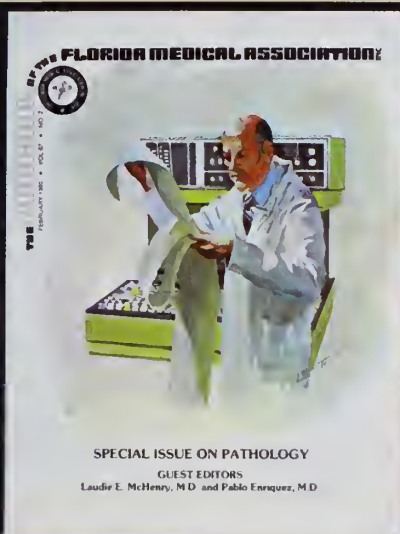
Digitized by the Internet Archive
in 2016

<https://archive.org/details/journalofflorida6819flor>



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

JANUARY 1981 • VOL 68 • NO. 1



SPECIAL ISSUE ON PATHOLOGY

GUEST EDITORS

Laudie E. McHenry, M.D. and Pablo Enriquez, M.D.

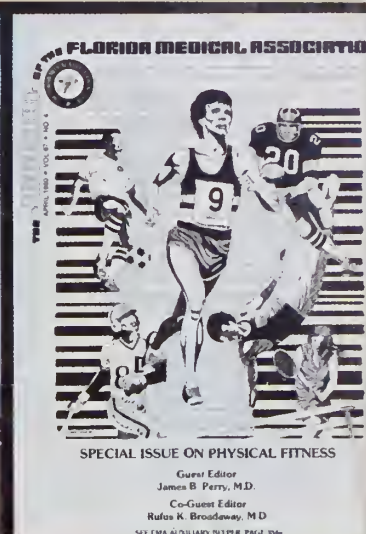


SPECIAL ISSUE

University of Florida College of Medicine

GUEST EDITOR

J. Lee Duckert, M.D.



SPECIAL ISSUE ON PHYSICAL FITNESS

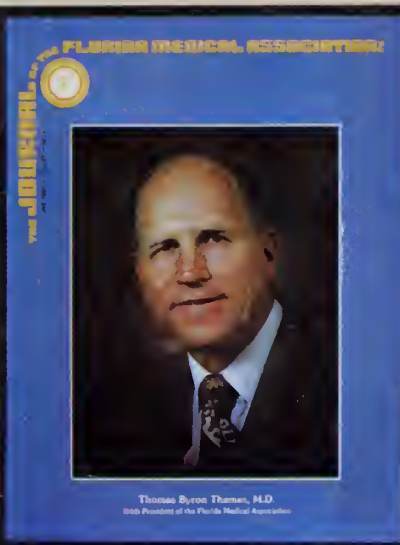
Guest Editor

James B. Perry, M.D.

Co-Guest Editor

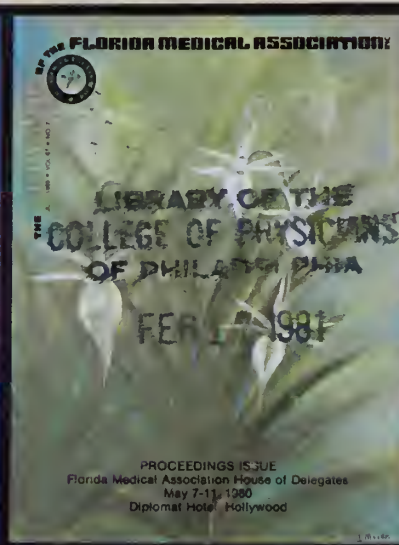
Rufus K. Broadaway, M.D.

SEE THIS JOURNAL IN TYPE PAGE 106



Thomas Byron Thomas, M.D.

With President of the Florida Medical Association



PROCEEDINGS ISSUE

Florida Medical Association House of Delegates

May 7-11, 1980

Diplomat Hotel, Hollywood



HISTORICAL ISSUE

William M. Straight, M.D.

Guest Editor



SPECIAL ISSUE ON FAMILY PRACTICE

Cranford O. Piker, Jr., M.D., Guest Editor



half-life

Just one built-in advantage

Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough

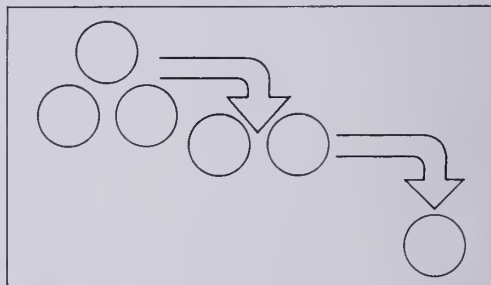
Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for

the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation

When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



*in the management of
symptoms of anxiety*

Valium®
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets

*effective therapy through
efficient pharmacodynamics*



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

JANUARY 1981 • VOL 68 • NO. 1 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.

E. Charlton Prather, M.D.

Assistant Editors

James K. Conn, M.D.

Lee A. Fischer, M.D.

Edward Pedrero Jr., M.D.

J. Lee Dockery, M.D.

(from Board of Governors)

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Susan L. Milhoan

Consulting Editorial Staff

William A. Alonso, M.D.
David S. Ashkar, M.D.
Robert A. Aronson, M.D.
Thomas D. Bartley, M.D.
Robert L. Batey, M.D.
Berre J. Bouls Jr., M.D.
S. Deborah B. Wilbur
William T. Branch, M.D.
Gael A. Brito, Jr.
Manuel L. Carbonell, M.D.
Donald W. Case, M.D.
Louis E. Cimino, M.D.
Charles Craig, M.D.
Jay Cummings Jr., M.D.
Julio deVelasco, M.D.
James E. Deming
Ablo Enriquez, M.D.
Richard A. Essman, M.D.
Franklin J. Evans, M.D.
Robert F. Feltman, M.D.
Richard Feinstein, M.D.
Lawrence M. Fishman, M.D.
John W. Glotfelty, M.D.
Alan L. Goldman, M.D.
Henry L. Harrell, M.D.
Alan Herskowitz, M.D.
James T. Howell, M.D.
Roy H. Hutchinson, M.D.
Rublin Klein, M.D.
Karl J. Kramer, M.D.
R. G. Lacsamana, M.D.
Richard F. Lockey, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
George A. Neder Jr., M.D.
Richard S. Panush, M.D.
R. A. Penalver, M.D.
John K. Petrakis, M.D.
Phillip B. Phillips, M.D.
Michael R. Redmond, M.D.
Albert L. Rhoton, M.D.
James F. Richards Jr., M.D.
Arvey I. Rogers, M.D.
Lees M. Schadel, M.D.
Guy T. Selander, M.D.
Roberto A. Sosa, M.D.
John Stone, M.D.
Edward J. Sullivan, M.D.
Robert H. Threlkel, M.D.
Benjamin E. Victorica, M.D.
Norman H. Wasserman, M.D.
Thomas M. Wiley, M.D.
Charles D. Williams, M.D.
Governor M. Witt, M.D.
Frederic C. Wurtzel, M.D.

Contents

Scientific Articles

- 21 The CO₂ Laser in Head and Neck Surgery
George L. Kullman, M.D.
- 24 Seven Years Experience with Tay-Sachs
Screening in Florida
Paul M. Tocci, Ph.D.
- 30 Foreign Bodies in the Stomach and Duodenum
James E. Crymes, M.D.
- 37 Potassium Supplementation: Comparative Studies in Edematous and
Non-edematous Patients
Thomas J. Merimee, M.D.

Special Articles

- 41 Febrile Seizures
- 43 Endoscopy in Upper GI Bleeding
- 43 Adjuvant Chemotherapy of Breast Cancer

Editorials

- 9 The House of Healing
Edward Pedrero Jr., M.D.
- 10 The Art of Medicine
James M. Ingram, M.D.

Organization

- 45 Robert E. Windom, M.D. Named to H.H.S. Advisory Panel
- 46 FMA/FMF Impaired Physician Program Gets First Medical Director
- 47 Concurrent Care—Necessary Vs. Unnecessary
- 49 JCAH Receives Kellogg Grant to Develop Hospice Accreditation
Standards
- 50 Oregon Sex and Marriage Expert to Keynote Annual Meeting
Scientific Program
- 51 Nine Large Florida Newspapers Visited by FMA
- 52 JCAH Surveys Set for Early 1981 For 36 Florida Hospitals

Departments

- 7 President's Page
Voluntary Effort or Government
T. Byron Thames, M.D.
- 19 Professional Liability Legal Update
- 59 Medical News Around the State
- 61 Correspondence
- 63 FMA Auxiliary
School Health—A Shared Responsibility
Mrs. Ben M. Crowder
- 65 Book Reviews
- 66 Books Received
- 67 Meetings
- 71 Classified Advertising
- 74 Index to Advertisers
- 74 FMA Officers and Council Chairmen

Cover

The cover this month is a montage of covers of *The Journal* which have been published during the past year.

Subscription Rate: \$15.00 per year, single copy. \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

easy to take



250-mg Pulvules®



Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes



Pediatric Drops

100 mg/ml
10-ml size

Keflex®

cephalexin

Additional information available
to the profession on request.



000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630



President's Page

Voluntary Effort or Government

With the advent of the New Year, a new President, and a new Congress, there is a new spirit in physician circles. I have seen it firsthand in my visits with medical societies and in my own medical community. It is a feeling of new hope that perhaps we can successfully remove some of the oppressive yoke of government and increased paperwork and go back to a simpler relationship of doctor to patient.

It is fueled by the promise of the new administration to allow us to attempt to solve the problems of access to medical care and rising costs of medical care on a voluntary basis instead of by more government regulation. However, if we can't or don't do it voluntarily, the threat of additional legislation is still there. We must dedicate our efforts toward finding worthwhile solutions to these problems. We all subscribe to the maxim that any ill person should have access to needed medical care and that no person should be impoverished because of medical costs for necessary services.

We have suggested to the President and Congress that a savings in the costs of medical care could be obtained by doing away with the funding for PSRO's and HMO's. Those functions performed by PSRO's could more easily and effectively be carried out by physician and hospital review committees without the costs of federal bureaucracy. Nor do we in private practice fear the competition of HMO's — we've been able to compete successfully with Kaiser-Permanente and other private HMO's in the past and will continue to do so in the future. We do object to the spending of huge sums of the taxpayers' money for feasibility studies and start up costs to subsidize HMO's to compete with private practice. We especially object to taxpayers' funds going to advertise HMO's and encourage enrollment in HMO's in competition with us in private practice. If the idea of this

type of medical practice is good, let it stand on its own merits and compete with private practice for the health care dollar.

We must not ignore the concern of the lay public over the increasing costs of medical care and their concern that a medical catastrophe to them or one of their family could lead them to financial disaster. On our November trip to all the major newspapers of the state, all of the editorial boards of the nine newspapers visited expressed interest and concern in this problem. They asked probing questions as to what the FMA and individual doctors were doing now and could do in the future to control costs and keep access to care available to the sick.

Dr. Sanford Mullen, John Thrasher, Sam Flowers and I, along with local medical society officers, admitted that in 1980 health care costs ran higher than the consumer price index for the first time since the voluntary effort began in 1978. We explained the various methods individual doctors and hospitals were using to keep inpatient services to needed levels and necessary studies and the education of physicians to the costs of studies they order. We discussed physicians continuing to keep their fee increases below the level of price and inflation increases. We discussed various other factors in continuing to attempt to solve these national problems in a voluntary way.

Your officers and the public know that the solution to these problems depend on all of us working together in this new year. Please do your part in voluntary restraint in fees and in continuing in every way possible to assist in solving these problems. We all will benefit — patients because of decreased concern over access to care and costs and doctors because of decreased government interference in the practice of medicine.

301023

SEP 28 1982

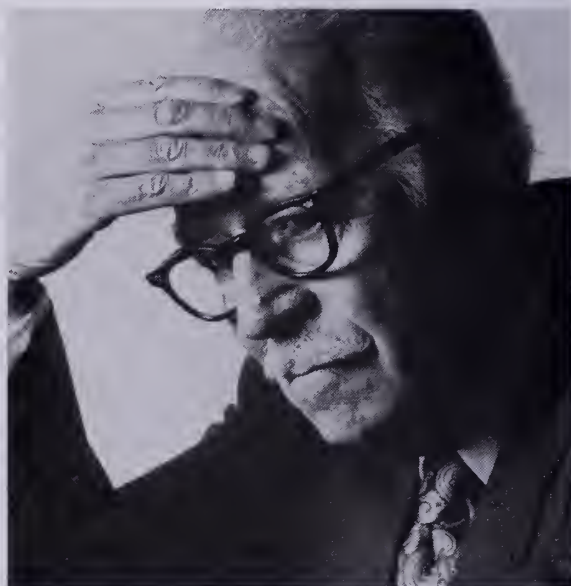
A TOTALLY NEW DELIVERY SYSTEM TO HELP REDUCE THE FEAR OF ANGINAL ATTACKS

Round-the-clock
protection with

ISO-BID

(ISOSORBIDE DINITRATE)

40 mg. capsules ... twice-a-day dosage



Controlled sustained release of ISO-BID's isosorbide dinitrate through micro-dialysis diffusion can help reduce frequency and intensity of anginal attacks. This in turn can minimize patient's fear of attacks, and dependence on nitroglycerin.

Unlike ordinary sustained release products, ISO-BID releases isosorbide dinitrate at a smooth, continuous, predictable, controlled rate to provide for up to 12 hours of therapeutic activity. Micro-dialysis is dependent only upon the presence of fluid in the G.I. tract and not on pH or other variables. ISO-BID is particularly advantageous in the prevention of nocturnal angina.

DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Some patients may require higher dosage levels. In these patients, dosage should be titrated, and they may require two ISO-BID capsules b.i.d. Not intended for sublingual use. Consult product brochure before prescribing.

THERAPEUTIC FOOTNOTE: IN TREATING ANGINA . . . FAILURES MAY RESULT FROM INADEQUATE DOSAGE. Reports in the literature indicate the usefulness of higher dosage levels of isosorbide dinitrate.^{1,2}

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness

and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

SAMPLES AND LITERATURE AVAILABLE.



GERIATRIC PHARMACEUTICAL CORP. BOX 68. FLORAL PARK, NEW YORK 11001
PIONEERS IN GERIATRIC RESEARCH
DEVELOPERS AND SUPPLIERS OF CEVI-BID • GER-O-FOAM • TESTAND-B



1. Shane, S. J.: Canadian Family Physician, November 1973. 2. Lemberg, L.: Practical Cardiology, February 1976.

The House of Healing

The world's hospitals have developed from a humanitarian sense of brotherhood. Despite their identification with suffering and illness, hospitals are concrete expressions of the world's spirit of loving and giving — a spirit that underlies both the money that was donated to build them and the services faithfully performed under their roofs.

Prince Asoka of India was one of the earliest recorded founders of hospitals; he endowed shelters for both men and animals three hundred years before Christ. These buildings were called *cikista* or houses of healing and were planned both to shelter the sick and to distribute medicines as our modern dispensaries do.

The Christian Era gave great impetus to hospital building; it taught that all men are brothers, that loving the unlovable, tending the helpless and relieving another's pain are God-given duties.

Hospitals in the last three decades have become highly organized institutions. A certain danger is inherent in highly organized institutions — the fragile essence of humanity and compassion is in danger of diffusing away like a gentle ghost. The spirit that is likely to replace it is symbolized by Strindberg's accurate, useful but dehumanized adding machine.

There are many diverse characterizations of American hospitals:

The American hospital is large, impersonal and dominated by elaborate technology.

The American hospital is the noblest expression of the philanthropic impulse.

The American hospital exists primarily to further the professional and economic interests of physicians.

The American hospital is a business run to show a profit for its owners.

The American hospital is often half-empty and many of its patients should be at home or in extended-care facilities:

The American hospital exists to serve the community.

Which of these diverse characterizations of American hospitals is correct? To some extent, all of them are. No other country has such a heterogeneous collection of institutions comprising its hospital system.

What do patients hope for in hospitals today? Naturally they wish their physician to possess the highest technical skill. But even more so, they yearn for simple human kindness to relieve their anxiety. Hospital staffs under emergencies and stress, seem to be impersonal mysteries, having neither time nor desire to notice such human weaknesses as fear, panic, apprehension, or desperate desire for reassurance and companionship.

Enlarging the hospital service staff improves the amenities the public has come to expect. While additional nurses and assistants certainly improve a hospital's capacity for considerate and equitable care, in my opinion a more intangible improvement is needed.

There is a need for a gentler attitude on the part of every person on the staff of the house of healing, from administrator, doctor, nurse to elevator attendant. Someone in each hospital must inspire all the staff with a spirit of kindness, patience and forbearance.

Some professionals may object that indulgence would be rewarded by endless childish, undisciplined demands by patients and families. This argument reminds one of the opposition met by Dr. Philippe Pinel, who staked his life on his conviction that the madmen he freed from their chains would not attack and kill, despite warnings from more conventional hospital administrators and doctors.

Pinel's courage did not result in disaster and men who had been chained and raving for decades improved at once under his mercy and trust. Pinel's reformation in hospital for mental illnesses was another step toward gentler and more solicitous care in hospitals.

The patient has a right to considerate, humane, and respectful care; to every consideration of privacy; to reasonable response to requests for services; and to know what hospital rules and regulations apply to his or her conduct as a patient. These are essentially a matter of staff courtesy.

No law forces a doctor, nurse, health professional or orderly to be respectful to a patient. Doctors and hospitals have not been sued for inconsiderate or disrespectful care. It is difficult to envision a successful suit for such an action. However, it is not certain what imaginative lawyers could probably come up with some type of action

based on any of the patient's Bill of Rights adopted in 1973 by the American Hospital Association.

Despite the elaborate mechanical and mathematical devices used in the modern house of healing, there must be a renaissance of respect for elements in man's personality that automatic analyzers and scanners do not disclose. Among these vital elements are self-respect, and need for love and regard for one's fellows and the universal desire to contribute in some way to the well-being of one's companions in life.

The basic and inherent desire of every health care

provider in the house of healing to do something for his less fortunate fellow must transcend religious dogma, political beliefs and geographical boundaries. The house of healing in providing comprehensive health care must be upgraded to provide more kindness, patience and forbearance.

Edward Pedrero Jr., M.D.
Assistant Editor
Tampa

The Art of Medicine

(Editor's Note: The following essay was presented as the charge to the 1980 graduating class of the University of South Florida College of Medicine. The commencement ceremony was held June 14, 1980.)

Since we first met in the adjoining theater, only a short three years ago, your lives have been, of necessity, one of unceasing effort to learn the science of medicine. Your minds have been pushed to the limit to retain the countless facts and data required to earn your degree.

Now, in the months ahead, you must travel a rather abrupt turn in the road. As first-year residents, your acquisition of scientific fact should continue unabated, but to this will be added the direct personal responsibility for patient care.

During this upward transition, the management of your own patients will involve not only the science, but also, in steadily increasing proportion, the art of medicine.

How might we identify this sometimes elusive term? The art of medicine may be defined as the application of a blend of scientific knowledge and approach, of everyday common sense, and, equally as important, of genuine compassion and empathy for the patient.

There is no more contradiction between the science of medicine and the art of medicine than between the science of aeronautics and the art of flying.

The art of medicine is untold centuries older than the science. Medicine is a natural art, conceived in sympathy and born of necessity. From the earliest instinctive

procedures, there has developed our discipline as we now practice it. Undoubtedly, it is enormously advanced, but still far from precise.

Sir William Osler wrote that "Medicine is a science of uncertainty and an art of probability." This is no less true today.

Dr. Charles Mayo, in the *Collected Papers of the Mayo Clinic*, remarked, "While medicine is a science, in many particulars it cannot be exact, so baffling are the varying results in varying conditions of human life."

Only in this century has the level of the science of medicine superseded the level of the art. The sharp wit of Lawrence Henderson perhaps reached an apogee when he observed in the *New England Journal of Medicine*, "Somewhere between 1910 and 1912 in this country, a random patient with a random disease, consulting a doctor chosen at random, had, for the first time in the history of mankind, a better than 50-50 chance of profiting from the encounter."

Today, in the 1980's, we are faced with yet another dilemma. In the past 30 years we have acquired more understanding of the human body than has been assembled during all of recorded history. This explosion of knowledge, while greatly beneficial to the health of the patient, seems to have carried physicians farther and farther away from the patient as an individual human being.

As we have learned to do so much more for the patient, we have begun to lose the faith, respect, and affection, which are so vital to patient care. The science has expanded, but the art appears to be declining.

Now is the time for the renaissance of the art of medicine, that indispensable melding of basic and clinical science, of stable reasoning, and of the ordinary milk of

Dr. Ingram is Professor and Chairman of the Department of Obstetrics and Gynecology at the University of South Florida College of Medicine.

human kindness.

Therefore, in the name of the Faculty of Medicine, I charge you, as indeed I charge ourselves; let your minds be disciplined by the thorough knowledge of the science of medicine. But, in the final count, let your care of the patient be the art of medicine.

in these three years you have added greatly to our lives. We deeply and sincerely wish you well.

*James M. Ingram, M.D.
Tampa*



The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment



**CONVENTION
PRESS, INC.**

2111 NORTH LIBERTY ST.
**JACKSONVILLE,
FLORIDA 32206**

PHONE 904/354-5555

CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia, and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

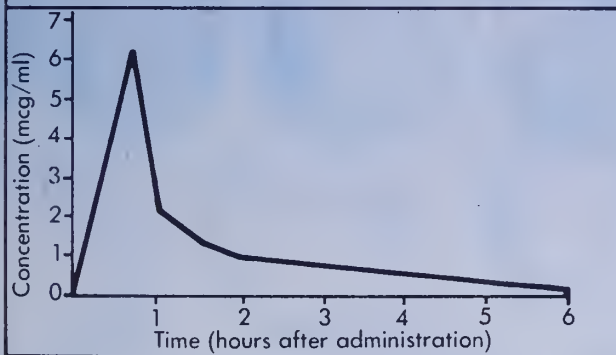
*Dosage should not result in a dose higher than that for adults.

†Depending on severity

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on $T^{1/2}$ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Wyeth Laboratories • Philadelphia, Pa 19101



Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.[†]

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN[®]-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

[†]Due to susceptible organisms.

See important information on facing page.

CYCLAPEN[®]-W
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW
NAME



Tail of whipworm
(*Trichuris trichiura*)

Vermox[®]: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX [®]	68% *	93% **
Mintezol ¹	35% †	45% ††
Antiminth ²	Not Indicated	
Povan ³	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX.[®]

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox[®] TABLETS
(mebendazole)



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.



**Broad-spectrum
coverage in mixed
helminthic infections**

Vermox[®] TABLETS
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX[®] in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX[®] in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

*Committed to research...
because so much remains to be done.*

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

TUTORIAL COURSES OF INSTRUCTION IN CORONARY CARE

Director: Louis Lemberg, M.D.

Co-Directors: Agustin Castellanos, M.D.
Robert J. Myerburg, M.D.

SCHEDULE OF COURSES 1981

January	19 - 24	July	13 - 18
February	9 - 14	August	3 - 8
March	2 - 7	September	14 - 19
April	6 - 11	October	19 - 24
June	15 - 20	December	7 - 12

(For more information please call (305) 325-6411 or complete coupon and mail to: Y. Barcena, Cardiology (D-39), University of Miami School of Medicine, P. O. Box 016960, Miami, Florida 33101).

Please send me more information regarding
Tutorial Courses of Instruction in Coronary Care

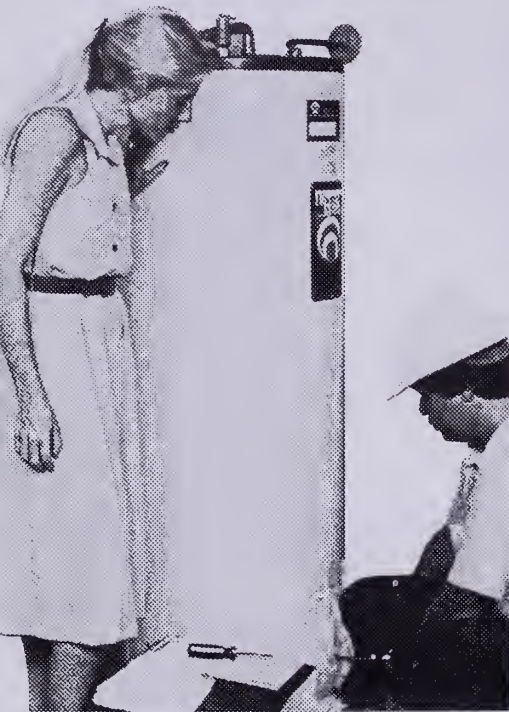
Name _____

Phone () _____

Address _____

ENERGY IS EVERYTHING.

SAVE IT AT HOME.



You can save a bundle of money right in your own home.

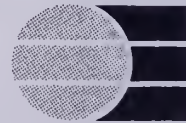
When you waste energy at home, you not only hurt your state and your country, you also hurt yourself and your family. Because you're literally burning up money that could be used for a lot of other worthwhile purposes.

Here are six easy ways for you to save energy at home.

1. Have a home energy audit to discover how you may save thousands of dollars on energy costs in the 80's. Call your local power company.
2. Keep your cooling-heating thermostat set no lower than 78° in summer, no higher than 65° in winter.
3. Keep your water heater set no higher than 120° (140° if you use a dishwasher). Wrap it with an insulating blanket. And turn it off when you're away for weekends.
4. Keep outside air out by caulking and weather stripping doors and windows.
5. Increase the amount of insulation where you live. Use window shades, trees and awnings to encourage natural cooling.
6. Send for Florida's tips on how to save money and energy at home.

Write: Save it at home, The Capitol, Tallahassee, Florida 32301.

In today's world, energy is everything. Save it at home. Save it, Florida.



SAVE IT, FLORIDA.

This message brought to you by The Governor's Energy Office and this publication.

An apple a day won't keep alcoholism away!

The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

Do you have a patient who needs this kind of help? You probably do because the illness is sneaky. For more information and guidelines on how to identify these patients, write to us.

Willingway Hospital

311 JONES MILL ROAD
STATESBORO, GA. 30458

(912) 764-6236

J.C.A.H. ACCREDITED



Is there a generic equivalent for drug research?



Estimated Drug Industry Investment in R&D*

Frankly, the dollars say no.

By the most generous estimates, generic manufacturers contribute barely 3% of the more than one billion dollars spent annually in the laboratories of American drug firms on research and development of new drugs.

For the last quarter of a century, virtually all of the major new drugs that imitators imitate have originated with a handful of research-oriented firms well known to all.

While our national investment in research has been declining steadily for a decade, the American pharmaceutical industry has actually been increasing its commitment, so that it now spends over five times the national average. No other industry dedicates a higher percentage of its profits to research. No industry in America depends less on government subsidies.

In the last two decades, the cost of in-

roducing a significant new drug has risen from roughly \$4,000,000 to over \$50,000,000, while its effective patent life has eroded from seventeen years to less than ten.

Today, the entire research and development commitment of ALL generic manufacturers combined is not enough to develop one single new drug entity.

When you prescribe generics, you switch profits from the innovators to the imitators...and R&D rarely appears on the imitators' budget sheets. Meanwhile, there are *real* people who may have to suffer and perhaps die needlessly if the incentives to progress are removed. It would be sad to abandon our commitment to the future in the short-sighted search for a bargain.

*Based on 1977 published figures available from National Science Foundation and/or Pharmaceutical Manufacturers Association

ROCHE

®

**Without the innovators,
there could be no imitators**

**THE MORTON F. PLANT HOSPITAL
AND
THE MORTON F. PLANT HEART CENTER**

Announce

THE FIFTH ANNUAL CARDIOVASCULAR SYMPOSIUM

February 20 - 21, 1981

The Sheraton Sand Key Hotel

Clearwater Beach, Florida

The 5th Annual Cardiovascular Symposium is devoted primarily to selected topics relative to the diagnosis and management of atherosclerotic coronary heart disease. The natural history, clinical recognition, non-invasive and invasive evaluation, as well as the surgical and non-surgical management, will be presented in detail.

Special presentations will also deal with the importance of clinical subsets in the evaluation and management of patients with atherosclerotic coronary heart disease.

An outstanding faculty has been assembled for the symposium which should be of interest to all physicians caring for patients with cardiovascular disease.

GUEST FACULTY

Robert O. Brandenburg, M.D.	Rochester, Minnesota
Robert S. Eliot, M.D.	Omaha, Nebraska
Stephen E. Epstein, M.D.	Bethesda, Maryland
J. Willis Hurst, M.D.	Atlanta, Georgia
Henry J. L. Marriott, M.D.	St. Petersburg, Florida
Carl J. Pepine, M.D.	Gainesville, Florida
Barry D. Rutherford, M.D.	Kansas City, Missouri
Hugh C. Smith, M.D.	Rochester, Minnesota
Myron W. Wheat, Jr., M.D.	St. Petersburg-Clearwater, Florida

As an organization accredited for continuing medical education, the Medical Education Committee of the Florida Medical Foundation designates that this continuing medical education activity meets the criteria for 10½ credit hours in Category I of the Physicians' Recognition Award of the American Medical Association. This program meets the Florida Medical Association continuing medical education requirement for 10½ hours of Florida Medical Association Mandatory credit. This program has been reviewed and is acceptable for 10½ Prescribed hours by the American Academy of Family Physicians.

RESERVATION FEES:	\$100 — all physicians \$ 50 — all paramedical personnel (nurses, technicians, etc.)
HOTEL RESERVATIONS:	Contact the Sheraton Sand Key Hotel on Clearwater Beach Phone: (813) 595-1611
REGISTRATION:	Make checks payable to: Morton F. Plant Heart Center — Symposium Donald R. Eubanks, M.D. (813) 441-5166 Program Director 323 Jeffords Street Clearwater, Florida 33517



Professional Liability Legal Update

Cardiopulmonary Resuscitation

The National Conference on Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC) held in September, 1979, developed standards and guidelines for CPR and ECC. These standards and guidelines have been developed as an updating of the standards for CPR and ECC published in 1974. They are intended for use as a working guide for the proper training and performance of cardiopulmonary resuscitation and emergency cardiac care. Because these standards are considered to be a "consensus" of many qualified persons from a variety of disciplines, they will obviously play an increasingly important role in establishing the standard of care in medical malpractice litigation. It is important, therefore, that physicians familiarize themselves thoroughly with these standards and guidelines.

Medico-Legal Aspects

Included among the standards and guidelines were considerations and recommendations concerning the medico-legal aspects of CPR. Of particular interest are the recommendations regarding the initiation or termination of CPR. According to the standards, few reliable criteria exist by which death can be defined immediately. Decapitation, rigor mortis, and perhaps evidence of tissue decomposition and extreme dependent lividity are usually reliable criteria. In the absence of such findings, CPR generally should be initiated immediately, unless there is an acceptable reason to withhold it. If the decision not to initiate CPR is made by a medical professional functioning in his professional capacity, the basis of the decision should not be arbitrary. The reason to withhold CPR should be sufficiently firm so that, should it later be subjected to question, a decision can be effectively supported.

When the victim of cardiac arrest is not the patient of the physician, a unique relationship may be created that may be described as the Good Samaritan-Victim

relationship, which provides statutory immunity under most circumstances. When a physician-patient relationship exists, the physician has an obligation to initiate CPR when medically indicated. Similarly, when a nurse or paramedical person is functioning in their official capacity, they have a positive obligation to initiate CPR when it is indicated.

A physician should continue resuscitative efforts until one of the following occurs:

- (1) The physician has reasonable assurance that the victim will continue to receive properly performed Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), or both.
- (2) The patient recovers.
- (3) The patient is found to be unresuscitatable and is pronounced dead.

The "Unresuscitatable" Patient

The patient may be considered "unresuscitatable" when he has been refractory to standard BLS and ACLS test measures that are available and adequate to test the responsiveness of the victim's cardiovascular system. While there has been a broad medical and ethical acceptance of the concept of brain death, a reliable assessment of brain recoverability at the time when the decision whether or not to resuscitate must be made is not possible in the large majority of cases. Thus, when the possibility of successful resuscitation exists, efforts should be initiated promptly while evidence of neurological function on the part of the victim in the course of resuscitation may favor brain recovery, absence of such evidence is not a reliable indication that the brain will not recover. Failure of properly applied BLS and ACLS to reestablish effective cardiovascular function, should be the basis for the decision to terminate resuscitative efforts, i.e., the basis on which the patient is deemed "unresuscitatable".

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

CPR by Non-Physicians

Non-physicians should initiate CPR to the best of their knowledge and capability in cases they recognize as cardiac arrest. The non-physician who initiates BLS or ACLS should continue his resuscitation efforts until one of the following occurs:

- (1) Effective spontaneous circulation and ventilation have been restored.
- (2) Resuscitation efforts have been transferred to another responsible person who continues BLS.
- (3) A physician or physician-directed person or team assumes responsibility.
- (4) The victim is transferred to properly trained personnel charged with responsibility for emergency medical services.
- (5) The rescuer is exhausted and unable to continue resuscitation.

The purpose of CPR is the prevention of sudden, unexpected death. CPR is not indicated in certain situations, such as in cases of terminal, irreversible illness where death is not unexpected. Credible medical support for this view has been offered. It has even been suggested that resuscitation in some circumstances may represent a positive violation of a person's right to die with dignity.

Brain Death

Brain death is widely accepted by legal and medical professions. Brain death is recognized legally, either through statute or case law, in most jurisdictions. When

strict criteria for brain death are met, life support mechanisms should be suspended. When brain damage is extreme and is considered to be irreversible, but accepted criteria for brain death are not met, a legally defensible decision to suspend life support efforts may be made by the physician, but the role of the family, the need for confirmatory medical consultation, or the need for the advice of an ethics committee may vary depending upon the situation.

For practical purposes, the family should be informed of the patient's status and prognosis and of the decision to terminate life support. If the family is in agreement and the medical assessment is complete and accurate, and there is agreement among care providers if there is more than one, there is generally no need for confirmation of diagnosis, prognosis, and plan by consultation. When there is substantive disagreement among physicians or between the responsible physician and a family member, the use of appropriate consultants is advisable, and the issue may ultimately be resolved in some cases only by recourse to a court or to a mechanism provided by or accepted by the courts in that jurisdiction.

Clarification, both medically and legally, of a decision-making process that provides for patient protection and also provides reliable guidelines for physician decision making is of critical importance in terms of both human and economic cost. At the present time, it is the single most pressing medico-legal problem in the area of CPR, ECC, and critical care at large. "Standards and Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)", *JAMA* 244:453, 504-508 (1980).

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

JANUARY, 1981
VOL 68 • NO 1

The CO₂ Laser in Head and Neck Surgery

George L. Kullman, M.D.

Introduction

Clinical applications of the carbon dioxide surgical laser in otolaryngology were reported by Jako and Strong in 1972.^{1,2} Previous reports of laryngeal laser surgery described the effects of different lasers and their characteristics;^{3,4} immediate damage induced by the laser as well as the healing of the lesion were also noted.^{5,6} The clinical application of lasers for localized destruction of small areas of epithelial tissue (such as polyps, carcinomas and papillomas) was described by Kaplan, Vaughn and Strong.^{7,8,9}

Since October 1978, I have used the 30 watt Cavitron surgical CO₂ laser to perform a total of 39 procedures in 34 patients. The procedures have been divided into 3 broad categories depending upon the laser delivery system. Firstly, lesions of the oral cavity and oropharynx are treated with the hand-held attachment without the use of the surgical microscope. Secondly, the laser is applied through a suspension micro-laryngoscopy route for lesions of the larynx. Thirdly, the laser is used through a 7 x 400 mm rigid bronchoscope to treat endobronchial lesions.

This presentation summarizes my experience with the CO₂ laser in head and neck surgery. Hopefully the data provided may be added to that of others,^{1,2,10,15} thereby, increasing our understanding of the advantages of this treatment modality.

The Author

GEORGE L. KULLMAN, M.D.

Dr. Kullman is an otolaryngologist practicing with the St. Petersburg Medical Clinic.

Clinical Data

A. Treatment by Direct Approach:

Three patients were treated for carcinoma of the oral cavity. Two had T₁, N₀, M₀,* lesions of the floor of the mouth anteriorly. The tumors measured approximately 1½ to 2 cm in diameter and extended onto the lingual surface of the mandible without fixation. Both lesions were extensively excised with the laser. The excision included the mucosa, submucosa and some of the most superficial fibers of the mylohyoid muscle; in addition, the mucosa and submucosa over the mandible were resected along with the periosteum. In the first patient there was no evidence of disease a year later at the time of death due to intercurrent disease. The second patient developed a local recurrence within 8 months and was treated with full-dose cobalt radiation. This patient died subsequently of primary and metastatic disease. In the third patient, a 1 cm localized squamous cell carcinoma of the free edge of the soft palate was excised transorally; there has been no evidence of recurrent disease in one and one-half years.

B. Treatment by Suspension Laryngoscopy:

1. Benign Lesions

*The American Joint committee on Cancer Staging and End Results Reporting developed the "TNM" system as a practical system of clinical classification of cancer. This provides an accurate evaluation of therapy through end result reporting of comparable malignant tumors.

Otolar. Clin. N.A., Oct. 69, 489-496.

Three patients aged 10, 27, and 62, were treated for juvenile papillomatosis previously excised by the cold knife method. In these patients there was no substantial decrease in the incidence of recurrence. The 27 year-old patient underwent 126 laryngoscopies for papillomatosis, the last 20 performed with the surgical laser.

Eleven procedures were performed for vocal cord granulomas in seven patients; only one had a de novo granuloma unrelated to previous surgery. Two patients required more than one treatment for elimination of the tumor. One has recurrent disease at this time.

Polyps of the vocal cords were removed in seven patients with uniformly excellent results, both in terms of postoperative voice and vocal cord appearance.

A unilateral ventricular cyst was removed in one patient, and at one year follow-up there is no sign of recurrence.

2. Premalignant and Malignant Lesions

Six patients were treated for leukoplakia and dysplasia occurring on the free vocal cords. Results were excellent with no sign of recurrence, regardless of the degree of dysplasia.

Seven patients have been treated for stage I squamous cell carcinoma of the larynx, one with stage IV.

3. Treatment with Bronchoscopic Attachment

Using the surgical CO₂ laser with bronchoscopic attachment, five procedures were performed on three patients with obstructing carcinomas located in the distal trachea and main stem bronchi. The procedures were considered palliative. Two procedures were required in two patients for satisfactory removal. All patients experienced complete relief of dyspnea without complications or untoward side effects. They were discharged from the hospital two to three days following surgery despite rather extensive excision. One patient died five months later from generalized carcinomatosis.

Case Reports

Case 1: An 81-year-old white man presented with a T₁, N₀, M₀ lesion of the right vocal cord extending from the vocal process of the arytenoid cartilage to and including the anterior commissure. No tumor was visible on the opposite cord.

Excision of the lesion included the entire vocal cord from the arytenoid cartilage to the anterior commissure and 1 mm of the opposite vocal cord. The patient did well postoperatively, however, within two months a 2 to 3 mm granuloma developed, and this was removed surgically with the CO₂ laser. A six-month healing process resulted in excellent voice quality with no apparent recurrence or metastases in one and one-half years of follow-up.

Case 2: 71-year-old white man experienced nasal dysfunction. Incidental laryngoscopy showed a neoplastic lesion approximately 3

mm in diameter located on the mid-portion of the right vocal cord. Further examination revealed a squamous cell carcinoma, staged T₁, N₀, M₀. The entire vocal cord from the vocal process of the arytenoid to the anterior commissure was removed for approximately 1 cm inferior to the free edge of the ventricular floor.

Benign granuloma formation within six months necessitated a second procedure. To date, there have been no signs of recurrent disease.

Case 3: 76-year-old man presented with a T₁, N₀, M₀ exophytic lesion of the left vocal cord extending over most of the free edge. The lesion stopped 1 mm from the anterior commissure and the vocal process of the arytenoid.

Excision with the surgical laser included the anterior commissure and some of the vocal process of the arytenoid. Vertically the excision extended from 1 cm inferior to the free edge of the cords superiorly into the depth of the ventricle.

The patient did well postoperatively, returned to excellent voice within six months and there has been no sign of recurrent disease.

Case 4: 69-year-old white man had a T₁, N₀, M₀ squamous cell carcinoma of the right vocal cord, anterior and middle third, not involving the anterior commissure. Total laser excision of the vocal cord was performed. Recovery was uneventful with no granulomatous formation and a resulting fair voice nine months postoperatively. There has been no sign of recurrent disease.

Case 5: A T₁, N₀, M₀ carcinoma of the false vocal cord was removed from a 59-year-old man by horizontal hemilaryngectomy 14 months prior to laser surgery. The patient had not refrained from smoking in the interval.

The original lesion was a well differentiated tumor. The recurrence was a squamous cell carcinoma in situ located in the free edge of the true vocal cord. The entire vocal cord was removed, and postoperatively the patient did well. There has been no recurrence in 12 months.

Case 6: 49-year-old white woman presented with granular change on both vocal cords. Biopsy revealed a T₁, N₀, M₀ squamous cell carcinoma of the left vocal cord with severe dysplasia on the right cord. The left vocal cord was removed from the commissure to arytenoid using the CO₂ laser procedure.

Postoperatively, a granuloma developed and required repeat laser treatment three and six months later. There has been no sign of recurrent carcinoma.

Case 7: 68-year-old man had very early squamous cell carcinoma, leukoplakic in appearance, of the mid one-third of the left vocal cord staged at T₁, N₀, M₀. The entire vocal cord from commissure to vocal process ventricle to 1 cm inferiorly was removed. Postoperatively, recovery was good and there has been no sign of recurrent disease. An excellent voice quality returned within three months after surgery.

Discussion

For endolaryngeal procedures the Cavitron CO₂ surgical laser is set at 50% of total power with continuous mode application. This appears to be the most effective technique for mucosal lesions in the upper aerodigestive tract including the mouth, pharynx and larynx. On the other hand, the unit has to be used at full power and continuous application for transbronchoscopic ablation.

The CO₂ surgical laser has produced excellent results in the treatment of vocal cord papillomas, leukoplakic conditions, and early vocal cord carcinoma. It is superior to conventional treatment because of the ease with which the surgery is accomplished and the minimal postoperative morbidity due to limited tissue reaction.

Large lesions of the oral cavity may be removed with little or no blood loss. The recurrence rate, however, does not appear to be substantially improved over conventional methods of excision.

In the one patient with stage IV squamous cell carcinoma, the laser was used to procure an endolaryngeal airway on an emergency basis, thus allowing time for general medical preparation and elective laryngectomy. This avoided tracheotomy with the attendant high risk of stomal recurrence postoperatively. In this case the patient presented with an obstructing glottic lesion and unilateral neck metastases.

A noteworthy advantage of the surgical laser in early carcinoma of the vocal cords is reduction of operating time from an average of one and one-half hours to about 10 minutes.

The addition of the bronchoscope to the laser unquestionably adds an entire new modality of treatment. Use of the attachment combined with pinpoint laser accuracy and general absence of tissue response has greatly facilitated surgical procedures. It is particularly effective in areas where access by conventional methods is difficult or impossible, and will undoubtedly prove an invaluable adjunctive form of treatment.

The surgical lasers' usefulness is modified by certain limitations. One is the inability to determine the exact extent of disease in various structures. This is particularly true if the tumor is markedly invasive. As in conventional surgery, best results are obtained by early removal

of what are presumably superficial lesions.

The absence of bleeding and postoperative morbidity as well as ease of application make the surgical laser a preferred instrument for appropriate lesion excision.

References

1. Jako, G. J.: Laser Surgery of Vocal Cords, *Laryngoscope* 82:2204, 1972.
2. Strong, M. S. and Jako, G. J.: Laser Surgery in Larynx, *Ann. Otol., Rhinol., Laryngol.* 81:781, 1972.
3. Kaplan, I. and Ger, R.: CO₂ Laser in Clinical Surgery, *Israel J. Med. Sci.* 9:79-83, 1973.
4. Vaughan, C. W.: Transoral Laryngeal Surgery Using CO₂ Laser: Laboratory Experiment and Clinical Experience, *Laryngoscope* 88:1399-1420, 1978.
5. Strong, M. S., et al: Use of CO₂ Laser in Otolaryngology: Progress Report, *Trans. Am. Acad. Ophthal. Otolaryn.* 82:595-602, 1976.
6. Hobeika, C. P. and Rockwell, J. R.: Laser Microsurgery in Experimental Otolaryngology, *Trans. Am. Acad. Ophthal. Otolaryn.* 76:325-333, 1972.
7. Polanyi, T. G.; Bredemeier, H. C., and David, T. W., Jr.: CO₂ Laser for Surgical Research, *Med. Biol. Eng.* 8:451-548, 1970.
8. Mihashi, S., et al: Laser Surgery in Otolaryngology: Interaction of CO₂ Laser and Soft Tissue, *Ann. N.Y. Acad. Sci.* 267:263-294, 1976.
9. Hall, R. R.: Healing of Tissues Incised by Carbon Dioxide Laser, *Brit. J. Surg.* 58:222-225, 1971.
10. Andrews, A. H. and Moss, H. W.: Experience with CO₂ Laser in Larynx, *Am. Ann. Otolaryn.* 83:462-470, 1974.
11. Jako, G. J.; Strong, M. S., and Polanyi, T.: Experimental Carbon Dioxide Laser Surgery of Vocal Cords, *EENT Month.* 52:36-37, 1973.
12. Strong, M. S.: Laser Excision of Carcinoma of Larynx, *Laryngoscope* 85:1286-1289, 1975.
13. Strong, M. S., et al: Laser Surgery in Aero-Digestive Tract, *Am. J. Surg.* 126:529-533, 1973.
14. Lyons, G. D.; Lousteau, R. J., and Mouney, D. F.: CO₂ Laser as Clinical Tool in Otolaryngology, *Laryngoscope* 86:689-691, 1976.
15. Lyons, G. D.; Lousteau, R. J., and Mouney, D. F.: CO₂ Laser Laryngoscopy in Variety of Lesions, *Laryngoscope* 86:1658-1662, 1976.

- Dr. Kullman, 501 11th Street, North, St. Petersburg 33705.

Seven Years Experience With Tay-Sachs Screening in Florida

Paul M. Tocci, Ph.D.

Abstract: Tay-Sachs disease is a recessively inherited, progressively degenerative disorder of the central nervous system. The cause, a lack of hexosaminidase A activity, results in storage of GM₂ gangliosides in the neurons eventually destroying them. Symptoms generally are noticed at six months to one year of life. They include macular degeneration, seizures, blindness and lead to death between twenty-four and forty-eight months of life.

This report covers the activities of a community out-reach program over a seven year period. Over 6,000 normal persons were tested during this time; most of them of European Jewish ancestry among whom the gene frequently is ten times higher than other groups. The outlines of the adult-oriented, voluntary heterozygote screening program, its implementation, the enzyme analysis and attitudes of the population at-risk are discussed.

Tay-Sachs disease is characterized by a progressive accumulation of lipid material (GM₂ gangliosides, Type I) in the lysosomes of neurones throughout the central nervous system. The affected child appears entirely normal at birth and even to five to seven months of age although the gangliosides have been accumulating from early in prenatal life. The cells of the central nervous system progressively degenerate due to the storage of this material and leads to death by three to five years of age. The disorder follows an autosomal recessive pattern of inheritance. The disease is 100 times more common in infants whose ancestry is central-eastern European Jewish (Ashkenazi). Approximately one in 3,600 Jewish children born is afflicted with Tay-Sachs as compared to one in 360,000 non-Jewish and non-Ashkenazi Jewish births.

The early signs of Tay-Sachs disease are hyperacusis which results in the startle reaction (an extension response to sudden, sharp but not necessarily loud sounds) and is usually the first characteristic symptom to appear,¹ and motor weakness which usually begins between three and six months of age. The infant may sit unaided and even pull to a standing position but usually never is able to walk. At four to six months difficulty in feeding, hypotonia and spasticity become noticeable and in most cases a cherry-red spot can be demonstrated in the fundus of the eye due to the deposition of gangliosides in the macular region.

Long-term, intensive hospital care is required after

one and one half to two years because feeding and complications of pneumonia and seizures become quite difficult for the parents to manage at home. The last few years of the child's short life are spent in a vegetative state. The average life is 40 months. Death is usually due to intercurrent infections including aspiration pneumonia. Besides the tremendous emotional costs to the family, which are impossible to calculate, the financial costs for medical and hospital care amount to \$10,000 to \$50,000 per year.

Almost 100 years ago Warren Tay, a British ophthalmologist, described the macular degeneration in a child suffering with progressive degeneration of the nervous system.² Bernard Sachs, an American neurologist, later reported similar findings and gave the disorder its first name "amaurotic familial idiocy."³ For obvious reasons the name was changed in the 1960s to Tay-Sachs disease and more recently to GM₂ gangliosidosis, Type I.

There is some controversy concerning the reasons for this disorder to be so common among the Jews. The history and culture of the Jewish people explain why the gene is relatively isolated to that group in Europe. The mutation probably occurred after the expulsion of the Jews from Western Europe to the Baltic in the 13th and 14th centuries. However, the reasons invoked to explain a prevalence of 1/23-1/30 in this group range from random genetic drift and the founder effect to differential fertility; and consanguinity.⁴⁻⁷ None of these arguments are as persuasive as that of heterozygote advantage. Myrianthopoulos and Aronson found that in a study of the cause of death of 306 grandparents of children with Tay-Sachs disease (TSD) only one had died of tuberculosis (TBC).⁸ The incidence for 21 other causes of death did not differ significantly from a contemporary control group living in the same area. They further showed that

The Author

PAUL M. TOCCI, PH.D.

Dr. Tocci is Director of the Biochemical Genetics Laboratory and Associate Professor of Pediatrics at the University of Miami School of Medicine, Miami.

the areas of Europe where most of 618 TSD grandparents lived had a TBC rate three times lower than neighboring areas.⁹ Thus, a relationship similar to sickle-cell anemia heterozygotes and carriers of the thalassemia genes to infestation by the malaria *fulciparum* parasite may be operating in the carriers of the Tay-Sachs gene to infection by tuberculosis.

In 1969, Okada and O'Brien discovered the biochemical defect in TSD to be the deficiency of hexosaminidase A (Hex A) activity in tissue cells and body fluids.¹⁰ This finding provided the basis for the biochemical diagnosis of affected children and for prenatal identification of TSD in the fetus in the beginning of the second trimester.¹¹⁻¹² Later, these same workers demonstrated significantly reduced levels of Hex A in obligate carriers of the TSD gene (parents of children with Tay-Sachs disease) compared to the levels found in the noncarrier.¹³ In 1970 Schneck et al performed the first prenatal diagnosis of Tay-Sachs disease.¹⁴ These discoveries led to the development of screening programs to detect carriers of Tay-Sachs disease in the Jewish segment of the population, by Kaback, in Baltimore in 1971.¹⁵

Because the disease occurs in a specific population and an accurate and relatively inexpensive test is available for carrier detection, couples who are both carriers and therefore at a 25% risk with each pregnancy of having a child with TSD can be identified before the birth of affected offspring. More importantly, the availability of a highly accurate prenatal test provides the means whereby these high-risk couples can have unaffected children selectively. Termination of the pregnancy of affected fetuses by abortion is not acceptable to all couples but other alternatives are available and presented to each couple who are both carriers: they may take their chances, which are 1 in 4 with each pregnancy for having an affected child; have no further pregnancies; adopt; or choose artificial insemination by a noncarrier sperm donor.

Program Implementation

Early in 1973 the decision was made to start a heterozygote detection program in south Florida because of the high proportion of Ashkenazi Jews in the population. The serum, leukocyte and amniotic fluid assays for Hex A were established in the laboratory.¹⁶ The noncarrier and carrier blood level ranges were determined for the population, and the enzyme assay for amniotic fluid was perfected. Leaders of the local community including the South Florida Rabbinical Council, Greater Miami Jewish Federation, South Florida OB-GYN Society, Mt. Sinai Hospital, and the March of Dimes, Birth Defects, were invited to cooperate in a steering committee along with parents of Tay-Sachs children and the Department of

Pediatrics of the University of Miami School of Medicine. The committee was charged with the responsibility of setting the parameters of the program, educating the public and scheduling screening sessions in the community. This committee is unique since it was the first one formed for such a program in the United States.

According to best estimates available in 1973, there were 250,000 Jews living in Dade and Broward Counties. Approximately one fourth were estimated to be in the childbearing years or about 60,000 persons between 18 and 45 years of age. The known cases of Tay-Sachs disease in this area, one to two cases per year, fit very well with this figure if one takes the birth rate for the white population in Dade in 1973, ten per 1,000, and the incidence of the disease, one per 3,600, there should be 1.4 cases of Tay-Sachs per year in a population of 250,000 Jews.

In 1973 the committee chose to have an adult oriented, voluntary program based on community education and mass screening sessions. In other words, the program would follow very closely the prototype developed by Kaback and O'Brien.¹⁵ The steering committee wished to separate its functions of education and sponsoring of screening sessions from the counseling, testing and prenatal testing of carrier couples which would be the sole province of the medical school. Fund raising was done by the Tay-Sachs and Allied Diseases Association of Florida, an organization of concerned parents. A coordinator acted as liaison among community groups and organizations, the steering committee and the medical school.

A speaker's bureau was set up composed of lay persons and physicians. Physician education was carried out at local hospitals and medical society meetings by physicians and lay speakers carried the message to interested lay groups at their local meetings. Television, radio and newspaper items, as well as booklets describing the program, were prepared for dissemination and distributed by the coordinators. Arrangements for mass screening sessions were made at temples and Jewish community centers.

Several weeks were spent in preparation for each mass screening session. The first was held in Miami in October 1973. Since then with decreasing frequency, 33 such sessions have been held with attendance ranging from 50 to 350 persons in a four hour period. The steering committee determined in 1974 that the geography and the social idiosyncracies of Dade and Broward Counties necessitated changes in the Kaback and O'Brien formula. Less emphasis was placed on mass screening sessions though four are held each year in various communities since they retain value for educating the public through the media and for maintaining interest in Tay-Sachs screening in the community. More emphasis was placed

on small, local clinics.

Several outlying clinics were established to collect blood specimens and offer counseling on a continuing basis. Today there are nine in Dade, Broward and Palm Beach Counties. Small screening sessions are coordinated with activities of several local blood banks that visit temples, colleges and other locations. Testing is now offered to all persons over 18 regardless of sex, marital status or ethnic background. Children under 18 are tested with parental consent but single persons are counseled extensively and reminded that they do not need knowledge of their genetic status for the Tay-Sachs gene until they are going to reproduce and that it may be more effective if they are tested after marriage with their partner. More than 95% of those so counseled have decided to wait rather than be tested while single.

Specimen Collection and Preparation

The majority of screening tests for heterozygotes are performed on serum samples. The serum hexosaminidases are extremely stable when specimens are stored at -20 C and, of course, serum is relatively easy to collect. The blood samples are allowed to clot, and serum removed and either assayed immediately or frozen and stored. They are delivered frozen to the central laboratory in Miami.

A number of factors may increase the apparent percentage of Hex B in serum and lead to false positive diagnosis of the heterozygous state. This occurs in most cases of pregnancy.¹⁶⁻¹⁷ Liver disease, birth control pills and diabetes have also been implicated.¹⁸⁻²⁰ The increase is due to an intermediate form of the enzyme which is also heat stable. The intermediate isoenzymes are found in serum almost exclusively and if at all only in very small quantities in tissues. Thus, verification of the genotype can be made in the false positive group by assay of the tissue enzyme activity. Since leukocytes are the most readily available tissue, they are widely used for this purpose.

One of the major difficulties in the program results from the pregnant woman who presents for testing since the serum assay is useless (*supra vide*). If the woman is less than 16 weeks pregnant we suggest that the husband be tested first. If the test reveals that he is a carrier then the pregnant woman's leukocytes can be analyzed. In turn, if the results suggest she is a carrier her parents or a close relative are tested. Amniocentesis is offered as the last resort. Since it takes three weeks to grow sufficient cells to assay much expense and anxiety are involved in the process. The foregoing schedule makes it obvious why a blood specimen should not be taken from the prospective parents if the woman is more than 16 weeks pregnant since the results may not become available until it would be medically imprudent to terminate

the pregnancy. This can be anywhere from 20-24 weeks gestation if all the assays are done in time and everything goes perfectly well, which in tissue culture is asking a lot.

Methods of Analysis

The determination of hexosaminidase A in the serum is based on the enzymatic release of a fluorescent label from an artificial tagged substrate (4-methylumbelliferyl-2-acetamido-2-deoxy-*B*-D-glucopyranoside*) by measurements of the fluorescence produced. There are two enzymes present in the serum and tissues capable of degrading this substrate (Hex A and Hex B), therefore the method depends on the preferential inactivation of hexosaminidase A by heat (56° for five minutes). The assay is completely automated so that the total activity (Hex A and B) and the Hex B are analyzed simultaneously on a Technicon II Auto Analyzer.**²¹ The total serum hexosaminidase activity minus the hexosaminidase B activity (which remains after heat inactivation) is equal to the amount of Hex A. (Hex A is calculated as a percentage of the total activity). Noncarrier and obligate carrier serum as well as serum from TSD children are assayed for every ten specimens of unknown sera.

The white blood cell enzyme assays are carried out by hand using heat inactivation at 52° for two and three hours and requires the separation of the white blood cells from whole blood with disruption of the cells by ultrasound. The leukocyte assay must be very strictly controlled or spurious results may be obtained.²²

Direct amniotic fluid determination of hexosaminidase A is carried out as with the serum test on the day the fluid is taken. The direct amniotic fluid hexosaminidase A determination by itself does not offer sufficient discrimination of values for the complete safety of the fetus. It is always necessary to culture the cells from the amniotic fluid for three or four weeks and then proceed with the enzyme analysis in the fashion described above for white blood cell enzyme assay.

Several dozen blood specimens of obligate heterozygotes (parents of Tay-Sachs children) and non-Jewish persons were analyzed for serum and leukocyte hexosaminidase A and B before any tests were attempted on specimens from the public. Counseling ellipses based on Bayesian analysis of this data were drawn according to the method of Gold et al²³ (Fig. 1).

A prospective questionnaire was given to 204 persons before they were tested. The questions were designed to get demographic data, establish motives for appearing for the test to assess attitudes towards the

*Purchased from Research Laboratories, LTD, Colnbrook, Buckinghamshire, England.

**Technicon Instruments, Tarrytown, New York.

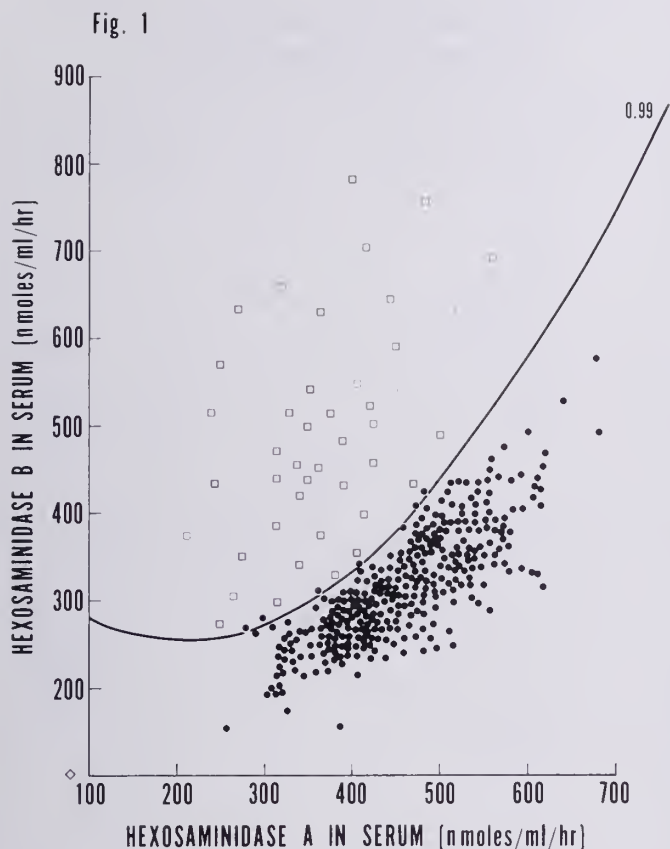


Fig. 1. — The solid line is the counseling ellipse or parabola which determined from the Gaussian bivariate density function that yielded the quadratic, $Ax^2 + 2Bxy + Cy^2 + 2Ex + F = 0$. The open squares represent values for Hex A + Hex B for parents of children that died of TSD. The closed circles are values for the two enzymes from non-Jewish persons with no history of TSD in their families.

program and test knowledge of the screening process including the genetics of the disease.

Results

Over 6,000 persons have been screened. Individuals with serum Hex A results in the noncarrier area of the counseling ellipse were counseled that they were noncarriers. Approximately 6% of the results fell in the carrier area. Those individuals were asked to submit another specimen. The serum was repeated and if again results were within the carrier area, a leukocyte assay was done. Slightly over one half of the people retested were true carriers and the remainder proved to be noncarriers by the leukocyte assay.

Partners of carrier-carrier marriages were tested by

Table 1. — Results of Screening Tests.

	Number of Persons
Number of individuals tested	6045
Number of carriers	234
Number of carriers in relatives	140
Number of at-risk couples identified	14
Carrier frequency	0.039 (1/26)
Number of amniocentesis	9
Number of fetal TSD diagnosis	1
Number electively aborted	1
Number of spontaneous abortion in unaffected fetus	1

duplicate serum and leukocyte assay and requested to have their parents or close relatives tested to confirm their status before they were counseled as "at risk" couples (*supra vide*). The summary of results are given in Table I.

Most practitioners are familiar with the effect of prevalence of a disorder, and the frequency of false positive and false negative laboratory results on clinical decisions but perhaps because genetic disorders are relatively rare and often exotic, many physicians forget that the same principles apply to these diagnoses. In the case of Tay-Sachs disease heterozygote testing the results are so interpreted as to ensure that no true carriers will be classified as noncarriers thus there is a 1% to 2% chance that persons who are noncarriers will have results in the carrier range of values. This is due to the arbitrary cut-off of 98% confidence limits in the assay and is called the conditional probability.

The conditional probability times the prior probability (the incidence of the heterozygous and nonheterozygous states in the population) equals the joint probability (Table 2). The posterior probability is calculated by dividing each joint probability by the sum of the two joint probabilities. Under the conditions listed on Table 2, the probability that a Jewish person with a first serum Hex A assay result in the carrier range is actually a carrier is 77%. If he is not Jewish the probability decreases to 25% (Table 3).

If both husband and wife are Jewish and found to be carriers by the serum assay the probability that they are both truly carriers is $.77 \times .77$ or 59%. If they are non-Jewish the probability is only 6%. To avoid subjecting these couples to unnecessary amniocentesis we require confirmatory testing by leukocyte assay for both husband and wife and have at least one close relative each confirmed a carrier by the leukocyte determination. This

Table 2. — Probability That a Jewish Person With Serum Hex A Value in Carrier Range¹ Is Truly Heterozygous for Tay-Sachs Disease.²

	Individual Is Heterozygous	Individual Is Not Heterozygous
Prior probability	1/28*	27/28
Conditional probability	100/100	1/100
Joint probability	0.03571	0.00964
Posterior probability	0.79	0.21

¹Limits are set such that 100% of heterozygous persons will be correctly determined and 1% of nonheterozygotes will have results in this range.

*Determination of heterozygote frequency in South Florida by leukocyte assay of Hex A in 6,000 persons.

²See Reference 23 for detailed discussion of the calculations used.

Table 3. — Probability That a Non-Jewish Person With A Serum Hex A in the Carrier Range¹ Is Truly Heterozygous for Tay-Sachs Disease.²

	Individual Is Heterozygous	Individual Is Not Heterozygous
Prior probability	1/300	299/300
Conditional probability	100/100	1/100
Joint probability	0.00333	0.00997
Posterior probability	0.25	0.75

^{1 2}See footnotes for Table 2.

discussion does not mean that screening for the Tay-Sachs gene is not worthwhile, but rather that such screening is too important to be carried out in less than an optimal manner.

Characteristics of the population are presented in Tables 4-6. Seventy-nine percent of those attending the screening were females; 36% of them came with their mates (58 couples). The mean age of the participants were 32 years. Most of the men were engaged in professional or managerial work while most of the wives were involved in teaching or sales work, 36% had some graduate training, 71% were college graduates and only 11% had no college experience. Forty-two percent of the persons tested had one or more children the average number being two per family; 50% planned to have more children. Eight percent of the women were pregnant at the time of testing.

The pretest counseling material stated that the principal reason for being tested was the elimination of the

Table 4. — Means of Discovery and Sources of Information of Tay-Sachs Screening.

QUESTION: How did you first learn about Tay-Sachs Screening?

Synagogue	25
Rabbi	1
Doctor	4
Newspaper	42
Radio/TV	4
Relatives	22
Other	2
TOTAL	100

QUESTION: Did you request more information?

YES	43%
NO	57%

If yes, from where?

Synagogue	18
Friend	25
Doctor	5
Rabbi	3
Relative	35
Tay-Sachs Program	14
Other	0
TOTAL	100

risk of Tay-Sachs disease by means of prenatal diagnosis and abortion of an unaffected fetus. Therefore it was not surprising that only five participants were categorically opposed to abortion and 17 refused to answer. Of the couples who attended together two (3%) disagreed on the question of abortion and in seven cases one or the other partner refused to answer. Thirty couples agreed that their decision on abortion was based on medical grounds, three couples based their decision on personal philosophy, 16 disagreed on the reason for their decision on abortion, and only one of these gave religion as the reason for opposing abortion.

Discussion

Voluntary mass screening for the Tay-Sachs gene meets all the criteria for screening to provide reproductive information: (1) a thorough knowledge of the course of the disease; (2) the disease occurs predominately in a defined population; (3) the heterozygous state can be simply, accurately and relatively inexpensively deter-

Table 5. — Knowledge of Incidence and Genetics.

QUESTION: What is the likelihood of your being a carrier?

Grade of School Completed	Correct	Incorrect	Don't Know
12	87%	9	4
16	72%	26	2
17+	73%	21	6

What is the incidence of Tay-Sachs disease in the Jewish population?

Grade of School Completed	Correct	Incorrect	Don't Know
12	17	57	26
16	37	54	9
17+	49	47	4

Can a couple have a child with Tay-Sachs disease if only one parent is a carrier?

Grade of School Completed	Correct	Incorrect	Don't Know
10-12	43	48	9
13-16	68	24	8
17+	70	22	8

mined; (4) prenatal diagnosis in early pregnancy is possible and selective abortion of affected fetuses is an alternative. Monitoring each pregnancy with amniocentesis gives the at-risk couple a positive alternative to have only unaffected offspring if they so choose, assuming they would elect to abort those pregnancies in which the fetus is found to be affected (25% risk with each pregnancy).

The persons who presented themselves for Tay-Sachs screening were a highly educated group having learned about it mainly from friends, newspapers, radio and television but not from physicians or rabbis. Although they knew that Tay-Sachs is a serious disease and that Jews are especially vulnerable, few knew much about the genetics of the disease, its frequency, or the incidence of the carrier state.

Our experience of Tay-Sachs testing has been a learning one. When people are made aware of the possibility that they may be at-risk for Tay-Sachs disease most of them take action to find out their individual status. They do so usually when they are planning a pregnancy or are already pregnant. The majority learn of the screening test from the media and very few are told by their physicians or rabbis. This may be the reason that when they wish to know more about the disease or the screening process they do not consult these sources, but generally

Table 6. — Attitudes Toward Screening and Family Planning.

QUESTION: How much would it matter to you if you were found to be a carrier?

	%
A great deal	51
Somewhat	14
Moderately	12
Hardly at all	20

QUESTION: How would it affect your plans for children?

(1) if you or your spouse were found to be a carrier?*

	%
No change	83
Have fewer children	5
Have no more children	12

(2) if both of you were found to be carriers?

	%
No change	53
Have fewer children	5
Have no children	42

Did any one try to deter you? If yes, was it a

	%
Friend or relative	3
Doctor	2
Rabbi	3

*Only those who answered yes to planning more children were graded on this question.

turn to friends, relatives or the program itself. The program would probably reach a much larger number of persons if physicians played a greater role in the dissemination of information since, as a rule, they are the ones most people turn to in questions of health.

Acknowledgements

We are grateful to Ms. Flora Brown for her capable technical assistance and to the Greater Miami Jewish Federation for its support in many areas of this project.

This work was supported by Project #288 of the Department of Health, Education, and Welfare, Foundation of Jewish Philanthropies, and the Florida Tay-Sachs and Allied Disease Association.

References are available from the author upon request.

- Dr. Tocci, University of Miami, Box 520006, Biscayne Annex, Miami 33152.

Foreign Bodies in the Stomach and Duodenum

James E. Crymes, M.D.

Abstract: The clinical and radiological findings of six patients with foreign bodies in the stomach and duodenum are presented. The various foreign bodies caused complications such as obstruction, ulceration, perforation, and/or migration in the peritoneal space. Prolonged retention in the stomach or duodenum may signify such a complication or may indicate an underlying obstructive lesion. Non-opaque foreign bodies require contrast studies for complete evaluation.

After they have passed out of the stomach, most ingested foreign bodies pass spontaneously through the gastrointestinal tract without any complications.¹ A small number of foreign bodies may become wedged in the stomach or duodenum and may lead to gastric outlet obstruction, ulcerations, or perforations. The symptoms caused by these complications present difficult diagnostic problems for the physician. These problems are often compounded by a lack of history of a patient swallowing a foreign object and by the fact that many of these ingested foreign bodies are not visible on routine x-rays. It is the purpose of this paper to show some of the unusual complications of foreign bodies in the stomach and duodenum.

Case Reports

Case 1. This 36-year-old woman was admitted to the hospital after a suicide attempt during which she swallowed several pieces of stainless flatware. There was a long past history of psychiatric illness with numerous previous surgeries for ingested objects. Anteroposterior and lateral films of the abdomen (Figs. 1A, 1B) showed several spoons and a fork in the stomach with no evidence of free air. At laparotomy two large soup spoons, two teaspoons, and one fork were successfully removed.

Case 2. This 22-year-old man was admitted to the hospital with abdominal pain and a history of having swallowed a pin two months before. Films of the chest and abdomen one month prior to admission had shown a needle in the left upper abdomen anteriorly with no free air (Fig. 2A, 2B). At this time the patient was asymptomatic and was sent home on a high bulk diet. Repeat films 20 days later showed that the needle had migrated downward from its former position, again with no evidence of free air (Fig. 3). A G.I. series revealed no perforations

and showed that the needle was anterior to the stomach and above the colon. At laparotomy, a rusty needle was found in the greater omentum with no perforations of the stomach. The patient had an uneventful recovery after surgery.

Case 3. Three days prior to admission to the hospital, this 22-year-old mentally-retarded male was seen at a local health center where he complained of abdominal pain. Films of the abdomen revealed a coin, which the patient did not remember swallowing. The patient was sent home on a high bulk diet; however, he continued to experience pain and vomiting. Films of the abdomen three days later showed that the coin had not moved from the right upper quadrant. A gastrografen G.I. series performed at the health center on the morning of admission to the hospital localized the coin to the second part of the duodenum and showed small bowel obstruction. The patient was referred to the hospital for possible surgery.

Plain films (Fig. 4A, 4B) again showed the coin in the duodenum with distended small bowel loops which were still filled with diluted gastrografen and no free air. A barium enema indicated a mobile cecum with no reflux into the ileum and no colon obstruction. A G.I. series revealed a linear web in the duodenum below the coin (Fig. 5) and a dilated small bowel with no filling of the colon at 4 hours.

At exploratory laparotomy a walled-off perforation of the distal ileum was found. The cause of the perforation and small bowel obstruction was not determined. The coin and web were removed from the duodenum. A follow-up G.I. and small bowel series several months later showed no residual obstructions.

Case 4. This 31-year-old woman was admitted to the hospital with nausea, vomiting, and abdominal distension. The patient reported swallowing a toothbrush ten days prior to admission.

The initial film of the abdomen (Fig. 6A) showed a dilated fluid-filled stomach with no evidence of free air. Metallic densities, representing the foreign body in the second part of the duodenum, were seen to the right of the third lumbar vertebral body. The patient's gastric outlet obstruction was treated conservatively with suction. A repeat film of the abdomen (Fig. 6B) showed no passage of the foreign body into the small bowel although the stomach was no longer distended. The orientation of the metallic densities had changed, however, because of a 90° rotation of the foreign body. A laparotomy and gastrotomy were performed and the toothbrush was found wedged in the second portion of the duodenum with the handle extending through the pylorus into the gastric antrum. No ulcerations or perforations were found and the patient had an uneventful recovery.

The resected toothbrush was x-rayed in air from the front (Fig. 7A) and from the side (Fig. 7B). The metallic sleeves in which the bristles

The Author

JAMES E. CRYMES, M.D.

Dr. Crymes is with the Division of Diagnostic Radiology, Department of Radiology, University of Miami School of Medicine, Jackson Memorial Hospital, Miami.



Fig. 1A. — Anteroposterior (AP) abdomen showing spoons and fork in stomach

were embedded were the densities seen in the duodenum on the abdominal films. The toothbrush was x-rayed in water (Fig. 7C) to show disappearance of the plastic in this fluid.

Case 5. This 22-year-old man was admitted to the hospital after swallowing a plastic bag containing cocaine. The foreign body, which simulated a gastric polyp, (Fig. 8) was outlined by air within the stomach on a plain film of the abdomen. The unruptured plastic bag was removed by laparotomy and gastrotomy without any complications.

Case 6. This 27-year-old woman was admitted to the hospital with abdominal pain. The patient reported that she had swallowed a plastic fork one month before.

Plain films of the abdomen showed no foreign body and no free air. Abdominal ultrasound was negative. A G.I. series showed the fork outlined by barium with the handle in the duodenal bulb and the tines of the fork sticking into the greater curvature of the stomach (Fig. 9). An ulcer was present at this point. There was no extravasation of barium and no obstruction.

At laparotomy and gastrotomy, the fork was found fixed to the greater curvature of the stomach and a 3.5cm ulcer was found at the site of fixation. The fork was removed and a wedge resection of the ulcer was done. The pathologist found inflammation and fibrosis involving the full thickness of the gastric wall with no perforation. The patient had an uneventful recovery.

Discussion

Only 1% of ingested foreign bodies lead to intestinal perforation.² Most of the perforations have been reported in the ileocecal area.^{3 4} Many foreign bodies have been seen in children with the highest incidence in the first two years of life.⁵ Lactobezoars have been reported



Fig. 1B. — Lateral abdomen

in neonates due to undiluted powdered milk.^{6 7} Ingested "pop-tops" from soft drink cans may cause respiratory or gastrointestinal symptoms in children.⁸ Foreign bodies in the gastrointestinal tract of adults have been related to psychiatric problems, previous gastric surgery,⁹ diabetes,¹⁰ and drug smuggling.^{11 12}

Several complications of foreign bodies have been illustrated by the cases presented in this paper. Long thin foreign bodies can become fixed at the angulated portions of the stomach or duodenum. The patient may develop gastric outlet obstruction with abdominal pain, nausea, and/or vomiting. Plain films of the abdomen localize metallic foreign objects and serial films show fixation of the foreign body (Case 1).

If the plain films show no evidence of intraperitoneal free air, then an attempt to remove the foreign body endoscopically should be attempted.^{13 14} If the foreign body is too large for removal, is too tightly wedged in position, or has migrated outside the gastrointestinal tract, operative removal is necessary (Case 2.) Foreign bodies from the second portion of the duodenum also may migrate into adjacent organs such as the right kidney.¹⁵

Retention of small metal foreign bodies in the stomach or duodenum on serial films over several days suggests underlying partial obstruction (Case 3). In children or young adults an anomaly such as a gastric or duodenal web may be the underlying cause for retention of the foreign body.¹⁶ In adults peptic ulcer disease, or neoplasms, may be the underlying causes of partial obstruction. Endoscopy and contrast studies should be done in



Fig. 2A. — AP abdomen showing needle in the left upper quadrant



Fig. 2B. — Lateral abdomen showing needle lying anteriorly

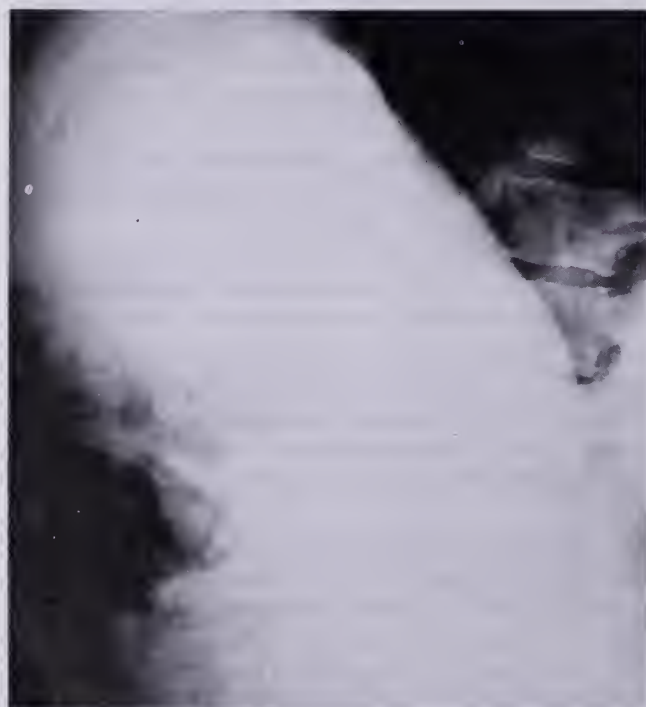


Fig. 3. — Lateral abdomen showing migration of needle downward



Fig. 4A. — Flat film of abdomen showing coin in second part of duodenum and dilated small bowel filled with diluted gastrografin



Fig. 4B. — Upright abdomen



Fig. 5. — G.I. series showing coin above web in duodenum



Fig. 6A. — AP abdomen showing distended stomach and foreign body in right abdomen



Fig. 6B. — AP abdomen showing foreign body still in same position in second part of duodenum



Fig. 7A. — Resected toothbrush in air from the front

such cases to determine the cause of the partial obstruction.

Many plastic foreign bodies are not radiopaque and cannot be seen on routine abdominal films. Some objects are only partially radiopaque which may cause confusion on plain films as to the true sizes and location of the object (Case 4). Contrast agents are required to localize such foreign bodies radiographically. Air surrounding the plastic object may render it visible radiographically (Cases 4, 5). Barium or water soluble contrast material can also be used (Case 6).

Ulceration of the intestinal mucosa may occur due to pointed foreign bodies or because of pressure erosion due to tightly wedged foreign bodies. Ulceration can be suspected clinically by the onset of abdominal pain or upper gastrointestinal bleeding. The diagnosis of ulceration associated with a foreign body can be made either endoscopically or by contrast studies (Case 6). Perfora-



Fig. 7C. — Resected toothbrush in water from the front



Fig. 7B. — Resected toothbrush in air from the side



Fig. 8. — AP abdomen showing foreign body simulating a gastric polyp with gas-filled stomach



Fig. 9. — G.I. series showing fork handle in duodenum with ulcer at points of the tines of the fork along the greater curvature

tion of these ulcers may lead to signs and symptoms of peritonitis or the demonstration of intraperitoneal air on plain films of the abdomen. Rarely, fistulae may develop from the perforation site to adjacent structures.¹⁷

Acknowledgement

I wish to thank Barbara Jones-Crymes, Ph.D., for her editorial and secretarial assistance.

References

1. Eldridge, W. W.: Foreign Bodies in the Gastrointestinal Tract, *JAMA*, 178, 665-667, 1961.
2. McPherson, R. C.; Karlan, M., and Williams, R. D.: Foreign Body Perforation of the Intestinal Tract, *Am. J. Surg.*, 94, 564-566, 1957.
3. Macmanus, J. E.: Perforations of the Intestine by Ingested Foreign Bodies: Report of Two Cases and Review of the Literature, *Am. J. Surg.*, 53, 393-402, 1941.
4. Maleki, M., and Evans, W. E.: Foreign Body Perforation of the Intestinal Tract. Report of 12 Cases and Review of the Literature, *Arch. Surg.*, 101, 475-477, 1970.
5. Alexander, W. J.; Kadish, J. A., and Dunbar, J. S.: Ingested Foreign Bodies in Children, *Progr. Pediatr. Radiol.*, 2, 256-285, 1969.
6. Pellerin, D.; Fortier-Beaulieu, M., and Gueguen, J.: The Fate of Swallowed Foreign Bodies. Experience of 1,250 Instances of Subdiaphragmatic Foreign Bodies in Children, *Progr. Pediatr. Radiol.*, 2, 286-302, 1969.
7. Cremin, B. J.; Fisher, R. M.; Stokes, N. J., and Rabkin, J.: Four Cases of Lactobezoar in Neonates, *Pediatr. Radiol.*, 2, 107-110, 1974.
8. Burrington, J. D.: Aluminum "Pop Tops" A Hazard to Child Health, *JAMA*, 235, 2614-2617, 1976.
9. Goldstein, H. M.; Cohen, L. E.; Hagen, R. O., and Wells, R. F.: Gastric Bezoars: A Frequent Complication in the Postoperative Ulcer Patient, *Radiology*, 107, 341-344, 1973.
10. Brady, P. G., and Richardson, R.: Gastric Bezoar Formation Secondary to Gastroparesis Diabeticorum, *Arch. Int. Med.*, 137, 1729, 1977.
11. Freed, T. A.; Sweet, L. N., and Gauder, P. J.: Balloon Obstruction Bowel Obstruction: A Hazard of Drug Smuggling, *Am. J. Roentgenol.*, 127, 1033-1036, 1976.
12. Dassel, P. M., and Punjabi, E.: Ingested Marijuana Filled Balloons, *Gastroenterology*, 76, 166-169, 1979.
13. Christie, D. L., and Ament, M. E.: Removal of Foreign Bodies From Esophagus and Stomach with Flexible Fiberoptic Panendoscopes, *Pediatrics*, 57, 931-934, 1976.
14. Honaas, T. O., and Shaffer, E. A.: Endoscopic Removal of a Foreign Body Perforating the Duodenum, *Canadian Med. Assoc. J.*, 22, 164-169, 1977.
15. Baird, J. M., and Spence, H. M.: Ingested Foreign Bodies Migrating to the Kidney from the Gastrointestinal Tract, *J. Urol.*, 99, 675-680, 1968.
16. Kassner, E. G.; Rose, J. S.; Kottmeier, P. K.; Schneider, M., and Gallow, G. M.: Retention of Small Foreign Objects in the Stomach and Duodenum. A Sign of Partial Obstruction Caused by Duodenal Anomalies, *Radiology*, 114, 683-686, 1975.
17. Justiniani, F. R.; Wigoda, L., and Ortega, R. S.: Duodenocaval Fistula Due to Toothpick Perforation, *JAMA*, 227, 788-789, 1974.

● Dr. Crymes, Department of Radiology (R-130), School of Medicine, P.O. Box 016960, Miami 33101.

Potassium Supplementation: Comparative Studies in Nonedematous and Edematous Patients

Thomas J. Merimee, M.D.

Abstract: The question of whether potassium (K) supplementation should be a routine part of therapy for patients receiving drugs enhancing K excretion was investigated in 46 subjects. Diuretic therapy caused a significant lowering of red blood cell and serum K which could be corrected or prevented in nonedematous patients by orange juice (35-40 mEq K per day). Edematous patients or patients prone to develop edema required more substantial K supplementation, usually 60 or greater mEq KC1 daily. Natural food products can provide all or some of the K requirements arising from diuretic therapy.

The major cause of hypokalemia in the American population is the use of diuretics, particularly thiazides. These compounds are known to act at the renal tubules inhibiting the reabsorption of both sodium and potassium.^{1,2} Citrus products are known to be relatively high in potassium content making their use for prevention and modification of hypokalemia a possibility.

A circumstance which complicates evaluating the use of any agent for potassium supplementation, however, is the nature of the underlying disease. Potassium loss can vary according to renal function and perfusion of the kidney. In this report we have examined orange juice supplements and orally administered KC1 (60-80 mM), in hypertensive subjects without edema and in subjects with documented edema secondary to congestive cardiac failure.

Methods

Study 1: Twelve control subjects, 18 hypertensive patients receiving either Diuril or Hydrodiuril (Chlorothiazide and Hydrochlorothiazide respectively) and 16 patients with documented congestive failure were studied. The causes of congestive failure were varied, with 8 subjects being in the idiopathic group and 4 subjects having failure secondary to long standing hypertensive cardiovascular disease. Two subjects had previous myocardial infarctions with subsequent episodes of failure requiring digitalization. Thiazides were initially started

at a dose of 1 gm of Diuril in two divided doses per day. All patients were followed at weekly intervals. When three consecutive serum potassium levels were 3.8 mEq per liter, patients were arbitrarily assigned to either supplementary potassium 60 mM q.d. or orange juice, one glass with each meal. Each glass contained 100 ml of juice with an average of 15 mEq of K. Serum and red blood cell potassium were determined at each of the weekly follow-up intervals, both in the control and supplementation period.

Study 2: Eight patients with hypertensive disease without edema and 4 patients with congestive failure newly diagnosed were placed on an orange juice supplementation program prior to the start of Diuril. Potassium was followed in this group at weekly intervals for periods of 10-15 weeks.

Red blood cell K and serum K were determined by flamephotometry. For determination of whole blood potassium, heparinized samples were obtained; these were hemolyzed with deionized water (0.2 ml of whole blood in 1.8 ml of deionized water). All blood samples were obtained from an antecubital vein without venostasis. Samples for serum potassium were twice centrifuged with the serum removed within 30 minutes of collection. Red blood cell potassium was determined by the formula, $K_{RBC} = 100/H (K_{WB} - K_s) + K_s$, where H = hematocrit, K_{WB} = whole blood K, and K_s = serum K.

Results

Table 1 summarizes the results of the two regimes of potassium supplementation in patients who developed hypokalemia while receiving thiazides. Control subjects had only a minimal decrease of potassium in serum and in red blood cells with thiazides. This decrease was statistically not significant. In nonsupplemented hypertensive patients without edema thiazides caused a significant decrease of both serum and red blood cell potassium which was corrected by both types of potassium supplementation. In patients with a prior or current his-

The Author

THOMAS J. MERIMEE, M.D.

Dr. Merimee is Professor of Medicine at the University of Florida College of Medicine, Gainesville.

Table 1: Red Blood Cell and Serum Potassium in Patients Receiving Diuretic Therapy

(See Methods)

	K (RBC) ¹	K (serum) ¹
I. Controls: (12)	97.2 (96.7-77.4)	4.3 (4.2-4.7)
Controls + Thiazide (12)	96.2 (94.8-98.6)	4.05 (4.0-4.5)
II. Hypertensive with Diuretics only: (18)	92.2* (89.6-94.0)	3.2* (3.0-3.6)
+ Orange Juice Supplement (10)	96.6 ^Δ (94-98.0)	4.2 ^Δ (3.9-4.4)
+ KC1 (60mM) (8)	96.9 ^Δ (93.8-99)	4.2 ^Δ (4.0-4.6)
III. Edema (Congestive Failure) and Diuretic: (16)	86.0° (81-92)	3.0° (2.8-3.6)
+ Orange Juice (8)	91.0* (87-95)	3.6* (3.1-4.0)
+ KC1 (60-80mM) (80)	96.0 ^Δ (92-98)	4.1 ^Δ (3.8-4.4)

¹ Values for K are given in millieq/liter. Means ± Range is given for each group.

* Differs from controls at the 1% level of significance

Does not differ from controls

° Differs from controls and hypertensive patients receiving diuretics

tory of congestive heart failure with edema, both serum potassium and red blood cell potassium were substantially less than in the hypertensive group only. Although both orange group supplements and potassium raised serum and red blood potassium in this group, the normal value was attained and maintained only by 60-80 mM of KC1.¹

In study 2, patients without edema did not develop hypokalemia while receiving from the start of the study both a diuretic and potassium supplementation by KC1. However, in subjects with edema, hypokalemia of a modest degree developed in those that were supplemented with orange juice only.

¹80mM KC1 was used on 2 patients who maintained low K⁺ (<3.5 mEq/L) after 4 weeks of 60mM KC1.

Discussion

The question of whether potassium supplementation should be a routine part of therapy for patients receiving drugs known to enhance potassium excretion has been much debated. It now appears that the nature of the underlying disease has a great deal to do with the magnitude of potassium loss subsequent to the use of diuretics. The question of adequacy or inadequacy of a given form of supplementation can thus only be answered by comparing appropriate groups of patients.

The key clinical determinant of the magnitude of potassium need would appear to be the absence or presence of edema during the clinical course. Hypertensive patients with no history of cardiovascular failure and edema have only a modest decrease of potassium with thiazides which can be both prevented and corrected by the amount of potassium contained in orange juice supplements as given. Subjects, however, that have edema, or a disease known to be prone to develop edema, do not maintain either normal serum potassium or red blood cell potassium with orange juice only. More substantial potassium supplementation is necessary in this group.

In the main these data are consistent with the best reports that have occurred in the literature. Morgan and Burkenshaw have reviewed the occurrence of potassium depletion in cardiac failure and have come to a similar conclusion regarding the severity of the potassium loss, i.e. potassium loss appears to be more severe in those patients who are prone to develop edema.⁶ Variations in the effect of thiazides on serum, red blood cell potassium, and potassium measured by other techniques can probably be explained by failure to clearly define the patient groups.⁷⁻¹⁰ Orange juice as given in this study would provide between 35-40 mEq of K per day, contrasting with 60 mEq, the usual daily supplementary dose of KC1. Even the latter is not completely adequate in patients with a history of congestive failure. Lastly, we would predict that in a study in which rigid adherence to therapy was not closely monitored, that compliance would be superior with the natural food product. All

Table 2: Effect of K Supplementation Beginning With Diuretic Treatment

	Control	Ten Week Follow-up	P
Hypertensive - Non-edematous Orange Juice	96.8 ± 3.4	96.1 ± 4.9	N.S.
Congestive Failure — Edematous Orange Juice	97.0 ± 2.6	89.4 ± 4.8	p < .05

K is given in millieq/liter. Figures are $\bar{x} \pm \text{SEM}$.

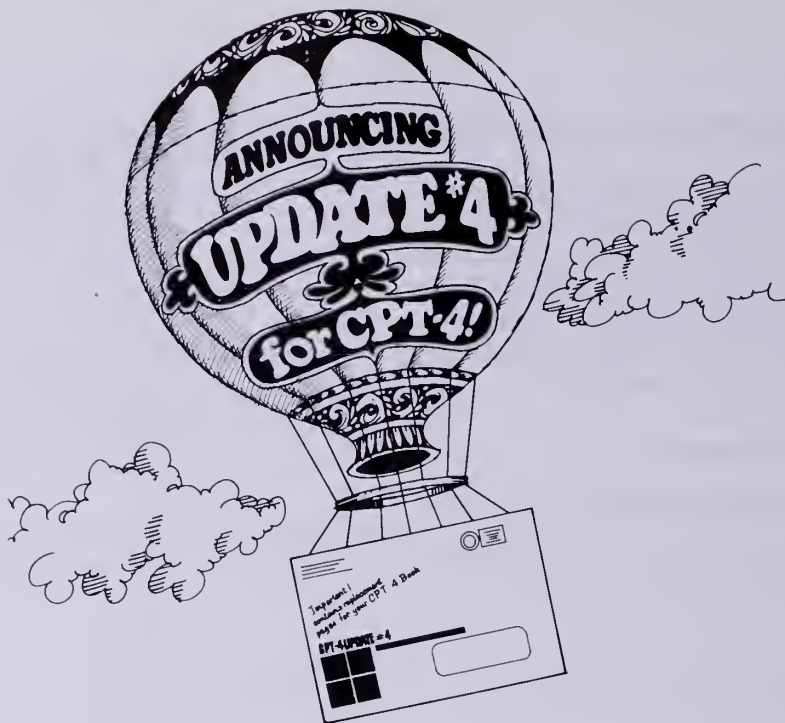
patients complained against the distastefulness of commercial preparations.

In summary, only modest potassium supplements are required in patients receiving thiazides who do not have edematous disease. Such supplementation can probably be met in most cases by natural food products. Patients that are edematous who likewise receive thiazides probably will require more potassium supplementation than is feasible via natural food products.

References

1. Norello, F.C.; Sprague, J.H.: Benzothiazine Dioxides as Novel Diuretics, *J. Am. Chem. Society* 79:2028, 1957.
2. Seldin, D.W.; Eknayan, G.; Suki, W.N.; Rector, F.C., Jr.: Localization of Diuretic Action From the Pattern of Water and Electrolyte Excretion, *Ann. N.Y. Acad. Sciences* 139:328, 1966.
3. Ibsen H.: Red Blood Cell K as a Measure of Body K on Thiazide-Treated Patients with Essential Hypertension, *Scand. J. of Clin. & Lab. Invest.* 34:161-165, 1978.
4. Boyd, D.W.: Red Blood Cell K and Aldosteronism. *Lancet* I., 594, 1970.
5. Soloff, L.A.; Kanosky, S.A.; Boutwell, J.H.; Rowell, D.: The Relationship of Electrocardiographic Pattern of K Depletion to Concentration of K in RBC, *Amer. J. Med. Sci.* 240:280, 1960.
6. Morgan, D. B.; Bunkenshaw, L.: K Depletion in Heart Failure and Its Relation to Long Term Treatment with Diuretics: Review of Literature, *Post Grad. Med. Journal* 54:72, 1978.
7. Ibrahim, I.K.: Are Potassium Supplements for the Elderly Necessary? *Age and Aging* 7:165-170, 1978.
8. Kohrakka, A.; Eisato, A.; Manninen, V.: Maintenance of Serum Potassium Balance During Diuretic Therapy, *Acta. Med. Scand.* 205:319-324, 1979.
9. Ramsey, G.E.; Boyle, P.; Ramsey, M.H.: Factors influencing Serum Potassium in Treated Hypertension, *QJ. Med.* 184:401-408, 1977.
10. Beevers, D.G.; Hamilton, M.; Harpour, I.E.: The Long Term Treatment of Hypertension with Thiazide Diuretics, *Postgrad. Med. J.* 47:639-643, 1971.

● Dr. Merimee, University of Florida, Box J-226, JHM Health Center, Gainesville 32610.



That's what keeps CPT-4 the most current medical reporting system you can use!

The 4th Edition of *Physicians' CURRENT PROCEDURAL TERMINOLOGY* is the only coding system that provides new and revised terminology on a regular, automatic basis. This latest update, Summer 1980 marks the fourth update since CPT-4 was published in 1977.

The updates are on self-adhering pages that are affixed to the pages they replace in CPT-4. To activate the update mechanism, you simply return the postage-free card in the book.

CPT-4 is a uniform coding system to accurately designate medical, diagnostic, and surgical services in terms of a uniform language among physicians, patients, and third parties.

Shouldn't you be using the most current coding system available?

Order two—one for yourself, one for your medical records clerk.

For information about CPT-4 in computer tape format, write: Dept. of Applied Medical Systems, AMA, 535 N. Dearborn, Chicago, IL 60610.

Order Dept., OP-41
American Medical Association
P.O. Box 821
Monroe, Wisconsin 53566

SJ



Please send me _____ copy(ies) of *Physicians Current Procedural Terminology, 4th Edition, OP-41*. Price: \$12 per copy. Enclosed is my check (payable to AMA) for \$ _____. Allow 4-5 weeks for delivery.

Name _____

Address _____

City/State/Zip _____

Febrile Seizures

(Editor's Note: The following reports are condensations of Consensus Development conferences sponsored by the National Institutes of Health. In each case, a full report may be obtained by writing the Office for Medical Applications of Research, NIH, Building 1, Room 216, Bethesda, Maryland 20205.)

A Consensus Development Conference on Febrile Seizures was held at the National Institutes of Health on May 19-21, 1980. The purpose of the conference was to bring together practicing physicians, research scientists, consumers, and others in an effort to reach general agreement on the risks of sequelae in children with febrile seizures and to compare them with the potential risks and benefits of prophylaxis with anticonvulsants.

The following is a synopsis of the Conference report.

What is a febrile seizure?

A febrile seizure* is an event in infancy or childhood, usually occurring between 3 months and 5 years of age, associated with fever but without evidence of intracranial infection or defined cause.

What are the risks facing the child who has a febrile seizure?

Children who suffer a febrile seizure generally enjoy normal health after the episode. Thirty to 40 percent of children who have one febrile seizure and who do not receive prophylactic therapy will experience a second.

During a seizure, there is additionally, a minimal chance of physical injury. A small percentage of children who have had a febrile seizure may have nonfebrile

seizures, that is, epilepsy. Significant risk factors separate children at high risk of developing nonfebrile seizures from those at low risk. The high risk group, for which one study showed a 13 percent incidence of epilepsy, is characterized by the presence of at least two of the following risk factors:

- a family history of nonfebrile seizures
- abnormal neurological or developmental status prior to febrile seizure
- an atypical febrile seizure, such as a prolonged or focal seizure.

What can chronic or intermittent prophylaxis accomplish in reducing those risks?

The risk of recurrence of febrile seizures can be reduced by the continuous daily administration of phenobarbital at appropriate dosage to achieve minimum therapeutic blood levels (about 15 mcg/ml).

Maintenance Therapy. Prolonged administration of phenobarbital is an accepted method of reduction of the frequency of febrile seizures. The long-term effects of such management are poorly understood.

Intermittent Therapy During Febrile Episodes. Intermittent oral phenobarbital in loading doses (i.e., — 15 mg/kg) is effective in preventing recurrence; but somnolence, lethargy and behavioral changes can be expected. Diazepam, when administered as suppositories (not yet available in the U.S.), apparently is absorbed rapidly enough to provide immediate protection from subsequent seizures in a high percentage of febrile children.

*A cerebral seizure is an abnormal, sudden, excessive electrical discharge of neurons (gray matter) which propagates down the neuronal processes (white matter) to affect an end organ in a clinically measurable fashion.

What are the potential risks of prophylaxis, using the available forms of therapy?

The potential risks of continuous prophylaxis are those predictable side effects, toxic manifestations, or idiosyncratic reactions that may be peculiar to the anticonvulsant drug selected for therapy.

Side effects and toxic reactions are reported in up to 40 percent of infants or children receiving phenobarbital:

1. Behavioral changes — hyperactivity to extreme irritability and, rarely, somnolence.
2. Sleep pattern disturbances — prolonged nocturnal awakenings.
3. Interference with higher cortical or cognitive functions, e.g.,
 - a. defect in short-term memory formation
 - b. inattentiveness or decreased attention span
 - c. defects in general comprehension.

Antipyretic therapy was not effective in preventing febrile seizures.

What is a rational approach to management of children with febrile seizures? Which children should be considered for prophylaxis?

A rational approach to the management of febrile seizures should take into account that the long-term prognosis is excellent, the prophylaxis reduces the risk of subsequent febrile seizures, and that there is no evidence that prophylaxis reduces the risk of subsequent nonfebrile seizures.

Anticonvulsant prophylaxis in therapeutic levels may be considered under any of the following conditions:

- a. In the presence of abnormal neurological development (e.g., cerebral palsy syndromes, mental retardation, microcephaly).
- b. When febrile seizure is:
 1. longer than 15 minutes, or
 2. focal, or
 3. followed by transient or persistent neurological abnormalities.
- c. History of nonfebrile seizures of genetic origin in a parent or sibling.

When anticonvulsant prophylaxis is instituted, it is usually continued for at least 2 years or 1 year after the last seizure, whichever is the longer period of time. Discontinuation of therapy should be done slowly over a 1- to 2-month period.

Parents and others who are responsible in the care of young children play a key role in the prevention and management of febrile seizures. Family education and counseling should address:

- the relatively benign nature of febrile seizures;
- the recognition of and management of fever;
- the use of antipyretic agents;
- medication and compliance;
- side effects of medication;
- first aid for a seizure; and
- when and how to seek emergency assistance, if needed.

Are further clinical, experimental, or epidemiologic studies necessary to help in answering these questions?

Studies are needed to address these issues:

1. Determination of risk factors predicting an initial febrile seizure.
2. Children with a history of febrile seizures should be followed into adulthood for exploration of any association between febrile seizures and learning disorders, epilepsy, behavior aberrations, intellectual development, and changes in the EEG.
3. Continued efforts to clarify the role of anticonvulsant treatment in febrile convulsions.
4. Pharmacological Studies
 - a. What anticonvulsants are safe and effective in short-term and chronic prophylaxis of febrile convulsions? What is the proper dosage and the therapeutic blood level?
 - b. What are the long-term risks of the use of the use of the above anticonvulsants?
 - c. Does phenobarbital enhance the possible carcinogenic effects of other drugs or chemical agents in humans?
5. Controlled study of antipyretic measures with the onset of febrile illness as a means of decreasing the risk of recurrence of febrile seizures.
6. Continuation of experiments of the effects of drugs on brain growth and development, utilizing animal and tissue culture techniques.
7. Continuation of animal experiments to clarify the effects of single recurrent seizures on brain maturation and development, utilizing both experimental animal models and kindling techniques.

Condensed by E. Charlton Prather, M.D., Associate Editor of *The Journal* and Health Program Supervisor, HRS District II, Tallahassee.

Endoscopy in Upper GI Bleeding

A Consensus Development conference held at National Institutes of Health recently covered this subject. A quarter of a million U.S. hospital admissions per year are necessitated by upper GI bleeding. The mortality from such bleeding is approximately 10 percent and has not decreased over the past years in spite of improvement in diagnostic accuracy and innovations in treatment. It was generally agreed that endoscopy, expertly performed, offers the best available method for identifying the bleeding site. The best interest to the public, they opined, is assured by the application of well defined professional standards for endoscopy. Contrast radiography is helpful in identifying the bleeding site in

about half the cases. Angiography rarely identifies the bleeding unless the blood loss is 0.5 cc/min. or greater. In spite of improvement, mortality is essentially unchanged but accurate diagnosis of the bleeding site makes rational therapy more likely.

A full report may be obtained from the Office for Medical Applications of Research, NIH, Building 1, Room 216, Bethesda, Maryland 20205.

Condensed by F. Norman Vickers, M.D., Pensacola. Dr. Vickers is Book Review Editor of *The Journal* and is engaged in the private practice of gastroenterology.

Adjuvant Chemotherapy of Breast Cancer

On July 14-16, 1980, the NIH sponsored a Consensus Development Conference on Adjuvant Chemotherapy of Breast Cancer. Participating were practicing physicians, research scientists, others active in oncology, and the ever present "consumer". The purpose was to attempt to reach a general agreement as to the best treatment for patients with various stages of breast cancer in the light of present knowledge acquired as a result of ongoing and anticipated clinical trials. The following is a summary of a recent report of this conference. All trials to date which have resulted in any significant statistics have been based on the initial treatment of patients with either radical or modified radical mastectomy. This provides optimal local control of the disease and permits staging. Through local control and staging, patients can be placed into prognostic sets and subsets. The general sets are (1) whether the patient is pre- or post-menopausal; (2) absence of metastases in all axillary lymph nodes; (3) presence of metastatic disease in 1-3 axillary nodes; (4) metastatic disease in more than 3 axillary nodes; and (5) whether the tumor is estrogen receptor positive or negative.

The major consensus was that many answers remain elusive and that widespread trials must be continued, modified, and extended. However, on the positive side, some definite recommendations can be made. There was general agreement that women who have no

nodal metastasis should receive no adjuvant treatment — either chemotherapy or radiation, since 80% may be expected to survive disease free for 5 years. Exposing the total set to definite risks of toxicity for the potential benefit to a very few was not felt to be justified.

Another consensus was that it has been quite well established that pre-menopausal patients with axillary node metastases obtain longer survival when treated with adjuvant chemotherapy. There was also agreement on the recommendation that if chemotherapy is to be used, multiple drug treatment is more efficacious than single drug treatment and must be administered in full recommended doses.

For patients falling into the other stages, there is still insufficient information available to make a definitive recommendation. Also, the roles of less than total mastectomy and irradiation of the breast itself in lieu of mastectomy are still undetermined.

The place of hormone manipulation as adjuvant treatment is also not clearly established, although the potential in this area is exciting. Controlled trials are needed before a consensus can be reached as to which patients are likely to benefit, in what stage, and what form the treatment should take. However, it is recommended that each tumor removed have its estrogen receptor status determined.

Finally, since there are definite acute and remote

toxic effects of chemotherapy, the report urges that the patient be frankly apprised of the stage of her disease, the prognostic status, and the factors that influence the recommendation for or against adjuvant treatment.

Condensed by James K. Conn, M.D., of Tallahassee. Dr. Conn is a general surgeon and serves as an Assistant Editor of *The Journal*.

ORGANIZATION

Editor's Note: As reflected in the following letter, FMA Secretary, Dr. Robert E. Windom of Sarasota has been appointed to serve on a panel of experts for the transition in the Department of Health and Human Services.

This opportunity offers the physicians of

Florida a direct means of participating in planning with the new Administration in an area vital to medicine. Dr. Windom has indicated that he would welcome any constructive ideas or advice physicians may have to offer him to be transmitted to other members of the panel.

OFFICE OF THE PRESIDENT-ELECT

WASHINGTON, DC 20270

December 1, 1980

Dr. Robert E. Windom
1750 South Osprey Avenue
Sarasota, Florida 33579

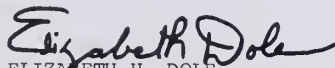
Dear Bob:

Thank you for your letter of November 13th and your generous assistance throughout the campaign.

I was pleased to learn of your interest in helping during the current transition period and would be delighted if you would consent to serve on our panel of experts for the transition in the Department of Health and Human Services. Mr. Robert Carleson is the team leader for the transition and he would greatly appreciate the opportunity to consult with you on specific matters within the jurisdiction of the department.

Bob and I look forward to seeing you at upcoming Senatorial Trust meetings and hope you won't hesitate to let us know if we can be of further assistance to you.

Sincerely,



ELIZABETH H. DOLE
Director
Human Resources Group

EHD:sbi

FMA/FMF Impaired Physician Program Gets First Medical Director

Dolores A. Morgan, M.D., of Miami, has been employed as Acting Medical Director of the Florida Medical Association and Florida Medical Foundation Impaired Physician Program.

The appointment of Dr. Morgan, who worked as a nurse before becoming a physician, was announced by FMA President T. Byron Thames, M.D., of Orlando; and Guy T. Selander, M.D., of Jacksonville, Chairman of the Foundation's Committee on the Impaired Physician. The position is parttime.

Dr. Morgan will be responsible for implementing a statewide program to rehabilitate physicians whose ability to practice is impaired by alcoholism or drug addiction. The foundation for the program was approved by the FMA House of Delegates last May.

A telephone "hot line" will be established in the near future and the number will be publicized. The "hot line" can be used either by physicians seeking help for their own alcoholism or drug addiction or by physicians,

spouses and others seeking assistance for other physicians.

Dr. Morgan is a native of Pittsburgh, Pa., and earned a Registered Nurse Diploma at South Side Hospital School of Nursing in that city. She later received a B.S. degree in nursing from Western Reserve University in Cleveland; and a M.A. degree in nursing education from the University of Pittsburgh.

Dr. Morgan later enrolled in the Indiana University School of Medicine and received her M.D. degree there in 1968.

She is a Diplomate of the American Board of Family Practice and Chairman of the Dade County Medical Association Impaired Physician Committee. She serves as Director of the Alcohol Treatment Program at South Miami Hospital.

Dr. Selander said a half-day Seminar on the Impaired Physician will be held at Lake Buena Vista on Friday afternoon, January 30, the day before the FMA Leadership Conference. (See following story).

Impaired Physician Workshop Precedes FMA Leadership Conference

A program entitled "Impaired Physician Workshop - Paving the Road to Recovery", the first major educational effort undertaken by the Florida Medical Foundation's Committee on Impaired Physicians, will be conducted at Lake Buena Vista later this month.

The 2½ hour program will get under way at 2:00 p.m. on Friday, January 30, at the Dutch Inn, the day before the opening of the Florida Medical Association Leadership Conference.

Mrs. Frederick J. Weigand of Deltona, FMA Auxiliary representative on the Committee and Conference Chairman, said any FMA or FMA Auxiliary member interested in the Impaired Physician Program is welcome to attend. Special invitations have been mailed to county medical society and FMA-recognized specialty group officers and executives and to component Auxiliary units.

FMA President T. Byron Thames, M.D., of

Orlando, will head the list of speakers. His topic will be "The Impaired Physician Program: Why It's Worth the Time, Money and Effort."

Other speakers will include: Guy T. Selander, M.D. of Jacksonville, Chairman of the Committee on Impaired Physicians; Dolores Morgan, M.D., of Miami, Medical Director of the Impaired Physician Program; and FMA Legal Counsel John Thrasher, of Jacksonville. Two recovering impaired physicians will address the workshop on the subjects of "It Couldn't Happen to Me" and "The Road Could Have Been Easier."

There is no registration fee for the workshop, but the Committee requests that persons planning to attend notify it of their intentions in advance if possible. Notices or requests for additional information may be addressed to: Mr. Edward D. Hagan, Director of Scientific Activities, Florida Medical Foundation, P.O. Box 2411, Jacksonville, Florida 32203, Telephone (904) 356-1571.

Concurrent Care — Necessary Vs. Unnecessary

Willard F. Manry, M.D.

One type of apparent overutilization shows up more frequently than any other in reviewing hospital experience of doctors who are singled out by the computer. This is the category of "length of hospital stay per patient".

Sometimes, a physician's unusual pattern of practice may specifically justify such protracted length of stay. A doctor called before Peer Review because of excessive length of a patient's hospital stay will usually point out that his cases involve older patients. Such patients are said to be more difficult to discharge earlier both because of their tendency to protracted illness, as well as difficulties encountered in transferring these patients to convalescent centers when needed. Of course, all other doctors with whom he is being compared deal with the same age group, are up against the same set of problems, and yet statistically the computer indicates a definite difference in practice patterns. To justify this difference without some explanation of the special elements involved, can be very difficult for the PMUR committee.

The most common explanation for excessive length of stay is to be found in the category of so-called "concomitant care" or "concurrent skills". This involves patient care by more than one doctor, with daily charges being entered by all physicians for the entire stay.

We are told repeatedly by physicians from one area or another, that this has been the routine practice in their area for many years, and that patients expect it. They also report that specialists simply will not write orders on any matter not pertaining to their particular field. This being the case, the doctor feels he must make daily rounds on the patient; hence, it is necessary and proper to make daily charges.

The PMUR Committee has a responsibility for seeing that appropriate payment is made in every case in which it is justified, but also must exercise careful judgment in evaluating charges entered when there is no apparent medical justification. In addition, the PMUR Committee has two items of published guidelines which

have been distributed to all doctors in Florida. One is from the "Medicine Ground Rules" section, page 18 of the Florida Medical Association Relative Value Studies Book dated 1975:

7. CONCURRENT SKILLS: When warranted by the necessity of concurrent skills of two or more physicians, such as medical services provided by primary physicians (presurgical assessment, etc.) who refers the patient to another physician, or as one or more consultants assisting in the care of the patient, the values for the services of each physician will be allowed.

The other reference is from "Medicare Notes", Volume 11, No. 9, May, 1980: Concurrent Care Policies:

Concurrent care is defined as necessary care by two or more physicians during the same time period for unrelated conditions. Concurrent care usually occurs when a second physician renders services that are more extensive than consultative visits. When the services of more than one physician are found to be medically reasonable and necessary (because of the existence of more than one medical condition) the services of more than one physician may be reimbursable. In order for the services of a second physician to be covered, medical documentation must demonstrate that diverse specialized medical services are indicated and medically necessary for the time period being billed.

When determining coverage of concurrent care, the patient's primary and secondary diagnosis, as well as the physicians' specialty and subspecialty are taken into consideration.* The patient's condition, and the medical necessity of such services will be determined by medical review of all necessary information (physician documentation, hospital records, etc.) It sometimes occurs, however, that claims for the second physician are denied in the original processing stage. Such claims can be resubmitted along with necessary medical documentation for medical review. We will obtain the necessary hospital records, complete the review, and advise the subscriber and physician as to the coverage decision reached.

*Concurrent Care: A diagnosis of a medical condition does not necessarily mean it warrants medical care by another physician during a hospital stay. For example, if a patient is hospitalized for a cholecystectomy and is also a hypertensive and/or diabetic, it does not necessarily mean that care needs to be rendered for the medical diagnoses.

In the eyes of the PMUR Committee, each physician has a personal responsibility to see that each charge he

This is the fourth in a series prepared under the auspices of the FMA Committee on Peer Medical Utilization Review.

Dr. Manry is a family practitioner in Lake Wales and is a member of the FMA Committee on PMUR.

makes is reasonable and justifiable. If attention is medically unnecessary, the mere fact that the patient expects a physician to visit does not make for a justifiable charge. "Social visits" in the interest of maintaining good relationships and for the overall encouragement of the patient fall into this category. Charges for such visits are unacceptable, and will not be paid by Medicare.

If you are in an area in which concurrent care is frequently practiced, it will often be classified as "unnecessary concomitant care" by the PMUR Committee unless you do two things:

1. Establish appropriate communications with other doctors attending the patient providing adequate information as to:

a) Your continuing status in the patient's care.

b) Categorize the request as to whether 1) you are requesting an opinion alone, 2) you wish the consultant to follow the case with you as long as he considers it necessary, or 3) you wish to transfer care of the patient to the consultant.

2. The other important item is documentation. This is important not only for medico-legal reasons, but also for justification of charges if the charts are reviewed a year or two later. Documentation should be detailed, especially in a situation of concurrent care, to not only offer an impression of the patient's condition, but also report the findings and treatment for a given day or interval. Also it should make clear that the attention of each physician was necessary. Finally, the entries should be legible to be classified as documentation.

JCAH Receives Kellogg Grant to Develop Hospice Accreditation Standards

The W. K. Kellogg Foundation has awarded a \$326,000 grant to the Joint Commission on Accreditation of Hospitals to develop quality standards and a model accreditation program for hospices.

The 18-month project will involve a study of the status and future directions of the hospice movement and the relationship of hospice care to other parts of the health care system; the training of surveyors and field testing of an accreditation program.

Fifteen operating hospice programs will participate in the pilot study. By March 1979 there were 59 operating hospice programs and an additional 73 programs in planning.

"It is timely to give attention to quality assurance aspects of these developing programs," according to Mr. Robert A. DeVries, a Program Director for the Kellogg Foundation. "The Joint Commission on Accreditation of Hospitals is uniquely qualified to carry out this mission."

Oregon Sex and Marriage Expert to Keynote Annual Meeting Scientific Program

A prominent Oregon physician has accepted FMA's invitation to keynote the "Stress and Lifestyle" theme at the 107th Annual Meeting of the Florida Medical Association.

Joseph B. Trainer, M.D., of Portland, Ore., will address a session of physicians and spouses and guests on Thursday evening, April 30, at the Diplomat Hotel in Hollywood, according to Calvin W. Martin, M.D., of Arcadia, Annual Meeting Scientific Program Chairman. Dr. Trainer's topic will be "Stresses of the Medical Family."

The Annual Meeting, which begins on Wednesday, April 29 and runs until Sunday, May 3, offers Florida physicians the opportunity to meet a full year's quota of Mandatory Credit (20 hours) under the FMA's mandatory program for members, and it's free! No registration fee is charged to FMA members.

Scientific programs, arranged mostly by FMA-recognized specialty groups, will be conducted on Wednesday afternoon, Thursday afternoon, all day Friday and Saturday morning. In addition there will be an Exhibit Hall full of technical and scientific and educational displays that will give FMA members additional opportunities to enhance their continuing medical education.

As usual, application will be made through the Florida Medical Foundation for AMA Category I Credit for the entire scientific program.

Dr. Trainer, Clinical Professor of Preventive Medicine and Public Health at the University of Oregon Health Science Center, has wide experience in writing and speaking and in radio and television productions on sex, marriage and health subjects. He is the author of "The Marriage Doctor", a column distributed by the Fort Worth Star-Telegram Syndicate.

He is the author of several articles and book chapters and serves on the Editorial Board of *The Journal of Marriage and Family Counseling*. He has worked with television programs entitled "The Marriage Doctor", "Marriage and More", "Perspectives II", "Dr. Joe Trainer" and "Family Medicine".

Meanwhile, Dr. Martin announced the following additional scientific sections:

FRIDAY MORNING, MAY 1

SECTION ON ALLERGY

(Co-sponsored by Florida Allergy Society)

8:30 a.m. to 12:00 noon

Richard F. Lockey, M.D., Tampa
Program Chairman

Welcome — Richard F. Lockey, M.D., Program Chairman, Tampa.

"Pharmacokinetics of Theophylline" — Saber Samaan, M.Sc., Division of Allergy and Immunology, University of South Florida College of Medicine, Tampa.

"The Use of the Radioallagisorbent Test (RAST) in Clinical Practice" — Robert E. Reisman, M.D., Clinical Professor of Medicine and Pediatrics, Division of Allergy and Immunology, University of New York at Buffalo, Buffalo, N.Y.

"Membrane Receptor Immunology — Clinical Implications" — Samuel C. Bukantz, M.D., Professor of Medicine and Director, Division of Allergy and Immunology, University of South Florida College of Medicine and Veterans Administration Hospital, Tampa.

"Hypersensitivity Diseases of the Lung" — Robert E. Reisman, M.D., Buffalo, N.Y.

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)

10:00 a.m. to 12:00 noon

Solomon Winokur, M.D., Lake Worth

Program Chairman

"Newer Developments in Electromyography" — Ernest Johnson, M.D., Professor and Chairman, Department of Physical Medicine, Ohio State University College of Medicine, Columbus, Ohio.

FRIDAY AFTERNOON, MAY 1

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic and Cardiovascular Surgeons)

2:00 p.m. to 4:00 p.m.

David S. Hubbell, M.D., St. Petersburg

Program Chairman

"Nonpenetrating Injuries of the Heart and Thoracic Vessels" — Peter Symbas, M.D., Atlanta, Ga.

"Update: Management of Chest Wall Injuries" — DeWitt Daughtry, M.D., Editor *Thoracic Trauma*, Miami.

"Update: The Medical Management of the Patient with Pulmonary Trauma" — Allan Goldman, M.D., Division of Pulmonary Medicine, University of South Florida College of Medicine, Tampa.

"Trauma of the Chest" — (Panel) Peter Symbas, M.D., Atlanta, Ga.; DeWitt Daughtry, M.D., Miami; Allan Goldman, M.D., Tampa.

Nine Large Florida Newspapers Visited by FMA

The seeds of open communication and understanding planted by FMA's leadership during last year's editorial tour around the state are paying dividends. Another visit was made recently to the nine largest circulation dailies in the state and the delegation received a warm reception from one and all.

That is not to say that all the statements and comments made to the editorial writers and publishers were accepted in total. Many of those in attendance asked searching questions in regard to various FMA positions.

Each session was opened by thanking these powerful opinion molders for fully airing the problems that led to FMA securing the recovery of cost legislation this past Spring. The fact that some of the publications did not agree with medicine's solution to the problem was acknowledged, but they had, in fairness, made the public aware that there is a continuing problem in the area of Professional Liability Insurance.

Keen interest was exhibited by all the newspapers in FMA's legislative goals and plans for the 1981 session. Such questions were answered by pointing out that at this point those goals have not been set by the Board of Governors. After the program has been determined, it will be to FMA's advantage to inform editors and publishers throughout the state, not only of our plans, but the reasoning behind them.

A topic of interest to everyone is Cost Containment. FMA is a party to and participant in the National Voluntary Effort Program dealing with the restraint of hospital

cost and physicians' fees. The newsmen were informed that the goals for this program were surpassed in 1978 and 1979, but were not being met as of the midpoint of 1980. Physicians' fees are still within the perimeters set, but it is almost certain that hospital costs will accelerate beyond the desired point for 1980.

The news people were told that FMA recognizes physicians play a large role in determining hospital costs. Specific examples were given as to ways physicians can be more aware of costs and help to hold them down during periods of hospital confinement.

The subject of Stress/Lifestyle was another topic of discussion. Several of the publications visited have carried articles on this subject in the past few months. They were encouraged to continue offering their readers this type of material. They were also told about FMA's plans for the scientific sections on this subject planned for the Annual Meeting. An offer was made to furnish them with copies of *The Journal of the Florida Medical Association* covering this matter.

Across the board, County Medical Societies in all the areas visited, have cordial relations with the media. This is extremely important to the advancement of organized medicine, and the officers and executives of those societies are to be commended for their efforts.

As had been said before, "too long has medicine labored in stoney silence while others seek to tarnish our image." The success story of medicine is surpassed by that of no other profession. It cannot be told without the understanding, cooperation and trust of the media.

JCAH Surveys Set for Early 1981 For 36 Florida Hospitals

The Joint Commission on Accreditation of Hospitals has announced that 36 Florida hospitals will be resurveyed during the first three months of 1981.

JCAH is soliciting, on a confidential basis any information about problem situations that surveyors should have prior to each visit. Information should be sent to Mr. John E. Milton, Deputy Director, Hospital Accreditation Program, JCAH, 875 North Michigan Avenue, Chicago, Illinois 60611.

Florida hospitals scheduled for survey are:

DeSoto Memorial, Arcadia; Glades General, Belle Glade; Holmes County, Bonifay; L. W. Blake Memorial, Bradenton; Hendry General, Clewiston; Cape Canaveral, Cocoa Beach; Doctors', Coral Gables; Mease, Dunedin; North Beach Medical Center, Fort Lauderdale; Citrus Memorial, Inverness; and Alachua General, Gainesville.

Lake City Medical Center and Lake Shore, both Lake City; Lakeland General, Lakeland; Lake Community, Leesburg; James E. Holmes Regional Medical Center, Melbourne; Baptist, Cedars of Lebanon Health Care Center, Douglas Gardens, and University of Miami Hospital and Clinic, all of Miami; and Everglades Memorial, Pahokee.

Fish Memorial, New Smyrna; Putnam Community, Palatka; Rehabilitation Institute of West Florida, Pensacola; Seminole Memorial, Sanford; Doctors Memorial, Perry; Apollo Medical Center, Palms of Pasadena, St. Anthony's and Edward H. White Memorial, all of St. Petersburg.

Hillsborough County, Tampa General and Memorial, all of Tampa; Tarpon Springs General, Tarpon Springs; and St. Mary's and Good Samaritan, both of West Palm Beach.

Fifty Years Ago

In *The Journal of the Florida Medical Association* for January 1931:

The medical staff of the Lake City VA Hospital was host to the Roentgenological Society for its semiannual meeting on December 4, 1930 . . . The Pasco-Hernando-Citrus County Medical Society met on December 11, 1930 at the home of **Dr. George R. Creekmore**, where "a real turkey dinner was served by Mrs. Creekmore" . . . Thirty-nine of 44 applicants taking the recent examination passed and were licensed by the State Board of Medical Examiners . . . A Fort Myers physician, charged with performing a fatal abortion on a Key West school teacher, was found guilty of manslaughter in Lee County Criminal Court . . .

And so it was in Florida medicine 50 years ago this month. — EDH

Twenty-Five Years Ago

In *The Journal of the Florida Medical Association* for January 1955:

Obituaries included that of former FMA President **Hermon Marshall Taylor, M.D.**, of Jacksonville, a key figure in the medical community of that city for 44 years . . . **George T. Harrell Jr., M.D.**, Dean of the University of Florida College of Medicine, addressed the Volusia County Medical Society on the institutional and academic program proposed for the new medical school . . . The editorial section expressed concern over the Social Security Amendments of 1955, especially a provision that would make permanently and totally disabled persons eligible to receive retirement benefits at age 50 instead of 65 . . . **G. Dekle Taylor, M.D.**, of Jacksonville, presented a paper on "The Problem of Reflex Esophagitis" at the Annual Meeting of the American Academy of Ophthalmology and Otolaryngology.

And so it was in Florida medicine 25 years ago this month. — EDH

DOCTORS ARE DIFFERENT

They know to send healthful gifts at CHRISTMAS. No sugar-laden candies will do. So this year, let Florida's Finest Citrus and Gourmet Seafood top your shopping list, and at the same time support the Florida Medical Foundation.

We have made a special arrangement with one of Florida's finest groves to offer you the top 1% of their entire crop, all superior quality fruit, for your gift-giving this year. This fruit is grove-fresh and brimming with NATURAL sweetness. Perfect for your family and friends.

Order Pak #30 - ½ Bushel (\$15.95), or Pak #55 - 1 Bushel (\$23.50). You may select all oranges, all grapefruit, or a special mix of ½ each. For complete selection, write or call for our free brochure.

Prices include USA delivery charges East of the Mississippi River. For other states add \$1.00 per pack — except add \$3.50 per pack to Washington, Oregon and California.

Ask about our 6 Month Fruit Plan, or our 3 Month Fruit Plan, too.

Brochures may be obtained from your local Chairman or President, or from:

FLORIDA MEDICAL ASSOCIATION
AUXILIARY

Mrs. C. Brooks Henderson
1610 S.E. 22nd Avenue
Ocala, Florida 32670
(904) 629-1211

You may order the Fruit Paks mentioned above by sending your check along with this convenient order form, or request brochures for other selections.

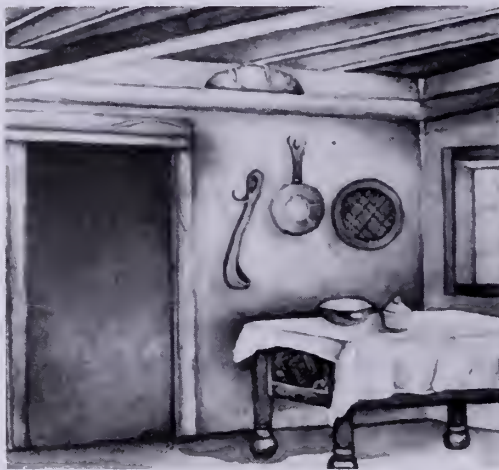
Make Checks Payable to "FMA-AUXILIARY-FMF", and remember, all benefits go to the FLORIDA MEDICAL FOUNDATION.

PLEASE SHIP THE FOLLOWING TO MY FRIENDS:

NAME _____	PHONE NO. _____	PAK NO. _____
ADDRESS _____	APT. _____	
CITY _____	STATE _____	ZIP _____
ARRIVAL DATE _____		
<input type="checkbox"/> ALL ORANGES <input type="checkbox"/> ALL GRAPEFRUIT <input type="checkbox"/> MIXED		PRICE \$ _____
VARIETY _____		ADD'L. SHIPPING \$ _____
FREE GIFT WRAP (SPECIFY) _____		TOTAL \$ _____
COMPLIMENTS OF: _____		
NAME _____	PHONE NO. _____	PAK NO. _____
ADDRESS _____	APT. _____	
CITY _____	STATE _____	ZIP _____
ARRIVAL DATE _____		
<input type="checkbox"/> ALL ORANGES <input type="checkbox"/> ALL GRAPEFRUIT <input type="checkbox"/> MIXED		PRICE \$ _____
VARIETY _____		ADD'L. SHIPPING \$ _____
FREE GIFT WRAP (SPECIFY) _____		TOTAL \$ _____
COMPLIMENTS OF: _____		
MY CHECK ENCLOSED FOR: _____		TOTAL \$ _____

Yesterday's Folk Remedy:

A rye loaf in the rafters.



Early in this century in Central Europe, almost every farm family kept a loaf of moldy rye bread on one of the kitchen beams. When any family member was cut or bruised, it was an old custom to cut a thin slice from the outside of the loaf, mix it into a paste with water, and apply it to the wound with a bandage. It was believed that no infection would then result from the cut.¹



Today's Tradition: **Tegopen[®]** (cloxacillin sodium)

for the treatment* of
known or suspected
staphylococcal
infections such as:

- Acute sinusitis
- Furunculosis and carbuncles
- Impetigo
- Secondarily infected dermatitis
- Cellulitis
- Abscesses
- Infected sebaceous cysts

In serious, deep-seated
staph infections, 500 mg
q.i.d. dosage is
recommended.[†]

- Tegopen has been reported active against 96% of *Staphylococcus aureus*.²
- 80% of *S aureus* has been reported resistant to amoxicillin and ampicillin.[‡]
- 88% of *S aureus* has been reported resistant to penicillins G and V.[‡]
- Staph resistance to erythromycin may develop during a course of therapy.³



Available as 500-mg and 250-mg capsules
and Oral Solution 125 mg/5 ml.

Tegopen[®] (cloxacillin sodium) Today's Penicillin for Today's Physician

1. Florey HW, Chain E, Heatley NG, et al: *Antibiotics*. London, Oxford University Press, 1949, p 2.
2. Bac-Data Bacteriologic Report, Professional Market Research, 1978-1979. The clinical significance of *in vitro* data is unknown.
3. Erythromycin prescribing information (in *Physicians' Desk Reference*, ed 34. Oradell, NJ, Medical Economics Co, 1980) states that staph resistance may develop during treatment.

See brief summary of prescribing information on
an adjoining page.

Copyright © 1981, Bristol Laboratories

*Note: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin.

[†]In serious, life-threatening infections, oral preparations of the penicillinase-resistant penicillins should not be relied on for initial therapy.

[‡]Not all isolates may have been tested using both discs.

Tegopen®

(cloxacillin sodium)
Capsules and Oral Solution

Brief Summary of Prescribing Information

For complete information, consult Official Package Circular
(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg q 6h.

Children: 50 mg /Kg /day in equally divided doses q 6h. Children weighing more than 20 Kg should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B. INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg in bottles of 100 500 mg in bottles of 100
Oral Solution—125 mg /5 ml in 100 ml and 200 ml bottles

BRISTOL®

Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201



**Join hands
with your
colleagues
around the world. . .**

**to improve
health care
for the people
of all nations**



The World Medical Association is medicine's international representative and advocate, dedicated to protecting and fostering the rights and interests of physicians and to improving the health care of the people of all nations. To achieve its goals, the WMA needs and asks your support.

Join the World Medical Association

World Medical Association
North American Region
536 N. State St.
Chicago, IL 60610

Yes, I wish to support the World Medical Association. Please send complete information and a membership application. (According to WMA bylaws, only physicians are eligible for membership.)

Name _____

Address _____

City _____

State/Zip _____

WANTED: Physicians who prefer medicine to paperwork.

We are looking for dedicated physicians, physicians who want to be, not salesmen, accountants, and lawyers, but physicians. For such physicians, we offer a practice that is practically perfect, where in almost no time you experience a spectrum of cases some physicians do not encounter in a lifetime, where you work without worrying whether the patient can pay or you will be paid, and where you prescribe, not the least care, nor the most defensive care, but the best care.

If that is what you want, join the physicians who have joined the Army. Army Medicine is the perfect setting for the dedicated physician. Army Medicine provides wide-ranging

opportunities for the student, the resident, and the practicing physician alike.

Army Medicine offers fully accredited residencies in virtually every specialty. Army residents generally receive higher compensation and greater responsibility than do their civilian counterparts and score higher on specialty examinations.

Army Medicine offers an attractive alternative to civilian practice. As an Army Officer, you receive substantial compensation, extensive annual paid vacation, a remarkable retirement plan, and the freedom to practice without endless insurance forms, malpractice premiums, and cash flow worries.

Army Medicine: The practice that's practically all medicine.

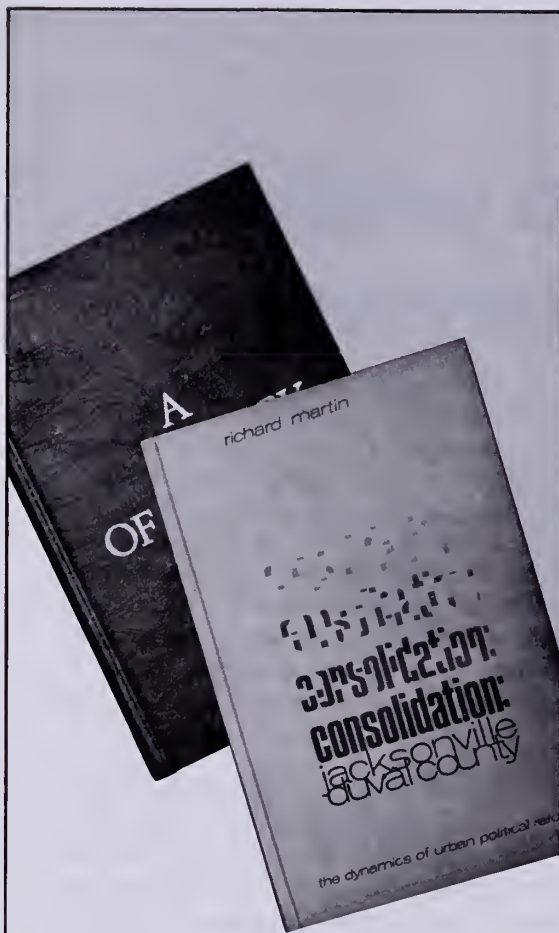
WRITE OR CALL COLLECT:

NORTHERN FLORIDA

MAJ. Roger D. Baderschneider, MSC
3555 Maguire Boulevard
Bennington Building, Suite 250
Orlando, FL 32803
(305) 896-0780

SOUTHERN FLORIDA

CPT. Vivian Sheliga, MSC
DuPont Plaza Office Building
Room 711
300 Biscayne Boulevard Way
Miami, FL 33131
(305) 358-6489



Distinctive Books For Professionals

Since 1964 publishers of quality case
bound and perfect bound books in
such diverse fields as Education,
Medicine, Politics and Art.

For information on producing your
book contact:

CRAWFORD PUBLISHING COMPANY

2111 North Liberty Street
Jacksonville, Florida 32206
Telephone 904/354-5555

A Division of Convention Press, Inc.

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levartanol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan[®]
for (lorazepam)
Anxiety

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.

The University of Miami School of Medicine . . . has established the Society for Research in Medical Education in honor of **Michael S. Gordon, M.D.**, Professor of Medicine.

Dr. Gordon is the creator of the Cardiology Patient Simulator known as Harvey, which can be programmed to display more than 50 symptoms to assist students in diagnosing various heart ailments. Harvey has had dramatic impact on the teaching and testing of health professionals.

Harvey was displayed at the 1978 Annual Meeting of the Florida Medical Association.

Dr. Gordon's outstanding achievements in research and education were cited by **E. M. Papper, M.D.**, Vice President of the University of Miami and Dean of the School of Medicine, at a testimonial dinner on December 5. "The University's belief in Dr. Gordon's future and that of his work is reflected in construction of the Medical Training and Simulation Laboratory that he directs," Dr. Papper commented.

A Canadian physician . . . has accepted appointment as Chairman of the Department of Medicine at the University of Miami School of Medicine.

E. M. Papper, M.D., Vice President for Medical Affairs and Dean, said **John M. McKenzie, M.D.**, accepted the appointment effective January 1. Dr. McKenzie comes from McGill University in Montreal, where he was Professor of Medicine and Associate Professor of Physiology.

A native of Scotland, the new Chairman received his medical degree from St. Andrews. He is a Fellow of the Royal College of Physicians, Edinburgh; and the Royal College of Physicians and Surgeons, Canada.

Dr. McKenzie is the author of 128 scientific articles.



Dr. Phillips

Philip B. Phillips, M.D. . . . of Pensacola, has been named President-Elect of the Southern Psychiatric Association. He was elected at the organization's annual meeting at Point Clear, Ala.

The Association is composed of 300 psychiatrists from 14 southern states. Membership is by invitation.

The American College of Physicians . . . has elected nine Florida physicians to Fellowship in the College. They will be formally inducted during the College's Annual Session in Kansas City, April 6-9, along with more than 250 physicians from other parts of the country.

The new Florida Fellows are:

Stanley L. Warren, M.D., Fort Lauderdale; **Craig S. Kitchens, M.D.**, and **Jawahar Mehta, M.D.**, both of Gainesville; **Theron A. Ebel, M.D.**, Lutz; **Horst J. Baier, M.D.**, Miami; **Allan Herskowitz, M.D.**, and **Charles L. Sprung, M.D.**, both of North Miami Beach; **Gene E. Myers, M.D.**, Sarasota; and **Jeffrey L. Miller, M.D.**, Tampa.

The Florida Hospital Association . . . has announced the appointment of **John M. McBryde** as President, succeeding **Jack F. Monahan, Jr.**, who retired after 27 years as the Association's chief staff officer.

Mr. McBryde joined the Orlando-based FHA in 1969 and was promoted to Senior Vice President in 1976. He assumed the presidency on November 7. Mr. Monahan was appointed to the new position of Senior Advisor as he begins a period of phased retirement until July 1981.

American Hospital of Miami . . . has been accredited for continuing medical education for a two-year provisional period.

The FMA Committee on Continuing Medical Education, meeting in Tampa on December 5, accepted the report and recommendation of a survey team which had visited the facility in September. Accreditation authorizes American Hospital to sponsor or co-sponsor continuing medical education courses and designate AMA Category I Credit.

The Committee on CME also renewed accreditation for four years each in the cases of the Florida Academy of Family Physicians; the Sarasota County Medical Society; the Orlando Regional Medical Center; and Hollywood Memorial Hospital.

Sixteenth Annual Postgraduate Course

“INTERNAL MEDICINE 1981”

February 28 — March 6, 1981

SHERATON BAL HARBOUR HOTEL

MIAMI BEACH, FLORIDA

The object of this course, the sixteenth in its series, is to provide an annual updating of the most useful recent advances in the diagnosis and management of internal medical disorders as they are encountered by primary care physicians and practicing specialists.

GUEST FACULTY

PETER T. MACKLEM, M.D.

Professor of Medicine and Chairman
Department of Medicine
McGill University
Montreal, Canada

EDGAR HABER, M.D.

Professor of Medicine
Harvard Medical School
Boston, Massachusetts

LOUIS WEINSTEIN, M.D.

Visiting Professor of Medicine
Harvard Medical School, Physician
Peter Bent Brigham Hospital
Boston, Massachusetts

SOLOMON PAPPER, M.D.

Distinguished Professr of Medicine and
Head of the Department of Medicine
University of Oklahoma
Oklahoma City, Oklahoma

J. WILLIS HURST, M.D.

Professor and Chairman
Department of Medicine
Emory University School of Medicine
Atlanta, Georgia

HIGHLIGHTS

**VIDEOTAPES OF TOPICS
FOR BOARD REVIEW IN
INTERNAL MEDICINE**

Selected topics in Internal Medicine updated by the University of Miami faculty and primarily designed for physicians preparing for Board certification in Internal Medicine will be video-taped in the evenings.

TWO MAJOR SYMPOSIUMS

Two major symposiums presenting "Management of the Medical Office" & "Cardiopulmonary Resuscitation" will be new features of the scientific activities.

**MEET THE FACULTY SESSIONS
“CRITICAL CARE IN
INTERNAL MEDICINE”**

Simultaneous group meetings will present topics of Critical Care in Internal Medicine. Special emphasis will be given to the most recent advances in the management of the critically ill patient.

**STATE OF THE ART LECTURES • AUDIO VISUAL AIDS • SCIENTIFIC EXHIBITS
HOTEL ATTRACTIONS • SOCIAL ACTIVITIES**

35 LECTURE HOURS AND 20 SELF-INSTRUCTION HOURS OF CREDIT, CATEGORY I, AMA

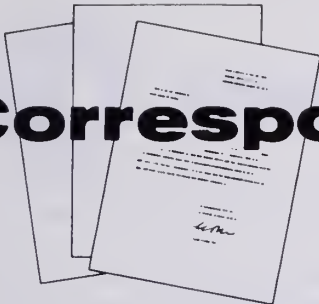
Registration: \$400/Physicians

\$250/Physicians-in-Training*

*Letter from Chief of Service must accompany registration.

**For Registration and
Information Write to:**

Jose S. Rocles, M.D.
Department of Medicine R760
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101
Phone: (305) 547-6063



Correspondence

OCTOBER ISSUE LAUDED BY AMA

To the Editor: I recently had the opportunity to review your October 1980 Journal which contained the excellent article by Dr. Thames and the superlative look at the AMA by Dr. Fischer. I enjoyed reading both.

The fact that your Journal has been so supportive of AMA membership drives and policy activities is of tremendous help to the whole of organized medicine. I just wanted to add my congratulations to what I am sure will be many others.

Best wishes for continued growth and even more informative articles in *The Journal of the Florida Medical Association*.

James H. Sammons, M.D.
Executive Vice President
AMA

FURTHER COMMENT ON TOXIC SHOCK SYNDROME

(The following letter was sent to the author of an article which appeared in the October issue of *The Journal* regarding Toxic Shock Syndrome. The author, E. G. Friedrich, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Florida, offers a reply to the comments made by Samuel M. Atkinson Jr., M.D.)

Dear Dr. Friedrich: Your article, in the October 1980 issue of *The Journal of the Florida Medical Association*, prompts the following thoughts on "Toxic Shock Syndrome" which I communicated to you by telephone.

"Toxic Shock Syndrome" (TSS) for all practical purposes is a new entity of the last five years. An adequate explanation for this phenomenon has not heretofore been advanced.

Your observations that synthetic fibers do cause vaginal ulcerations and that any tampon could be "... a fomite for the introduction and subsequent growth of the toxin-producing organism ..." do not adequately explain

why the TSS is seen in men, non-menstruating women, and children. Nor does it explain why the syndrome suddenly appeared five years ago.

As a practicing obstetrician-gynecologist I have noted a significant increase in vulvar lesions due to staph aureus over the last five years. The literature is replete with recent references to staph and strep outbreaks in our newborn nurseries. Untold deaths in newborns have occurred. I believe that the flora of the vulva has changed in the last 5 to 6 years and this change in the flora is due to the unwise and unwitting removal of hexachlorophene from the market place by order of the FDA under pressure from Ralph Nader organizations.

I suggest that all patients with a history of vulvar furuncles or abscesses, and most particularly those with active lesions, should be cautioned not to use tampons of any kind. These patients, along with pregnant patients in the last trimester, should be encouraged to use a surgical cleansing soap containing either chlorhexidine gluconate, providone iodide, iodophor, or hexachlorophene. These are expensive and difficult to use for routine bathing.

Until recently, I have been prescribing Gammophen surgical scrub soap (3% hexachlorophene), distributed by Arbrook, Inc., of Arlington, Texas. I am informed that this product is no longer produced. Reasons cited are the increased cost and limited availability of hexachlorophene, as well as a decrease in sales resulting from negative publicity regarding hexachlorophene. Hopefully the manufacturer of Gammophen can be encouraged to return it to the prescription market place.

Lastly, I call upon the FDA to review its ban on the non-prescription use of hexachlorophene and urge your support of research and action in this area.

Samuel M. Atkinson Jr., M.D.
Fort Walton Beach

Reply to Dr. Atkinson

I applaud the interesting suggestion proposed by Dr. Atkinson that human skin flora have changed in their quality or quantity following removal of hexachloro-

phene-containing products from the general marketplace.

Unfortunately, we have no data on vulvar skin bacteriology pre-dating the demise of hexachlorophene. Hence, there is no scientific basis for comparison. Nonetheless, the suggestion is a provocative one and leads directly to the prophylactic suggestion made by Dr. Atkinson. I certainly agree that the use of germicidal soaps and solutions for vulvar hygiene in those patients who choose to use tampons during their menses is a sensible recommendation and may decrease the likelihood of the occurrence of toxic shock syndrome.

*Eduard G. Friedrich Jr., M.D.
Professor and Chairman*

FLAMPAC HAS BANNER YEAR

To the Editor: 1980 was an exciting and successful year for the Florida Medical Political Action Committee (FLAMPAC)! We supported winning candidates in 101 contests and the losers in 19 races, for an overall success rate of 84%. Ten candidates in the General Election were targeted for maximum financial and staff support, and all of these were winners!

As impressive as the numbers are, much more important was the very active local work in campaigns by physicians, their spouses and families. In several races, these local support efforts spelled the difference between victory and defeat. Countless hours were spent by the medical family in carrying out the "people" projects that are so essential for a winning campaign. This included hosting coffees and cocktail parties, manning phone banks, stuffing and mailing of campaign materials,

walking precincts and standing at intersections with campaign signs.

While FLAMPAC contributed \$140,000 to the various candidates, this was more than matched by the funds raised by local M.D.s on behalf of these campaigns.

The candidate selection process was vital in the determination of where FLAMPAC's resources would be channeled.

The FLAMPAC Board supported candidates based on recommendations of local selection committees, which are composed of M.D. and spouse members of FLAMPAC. These committees began screening candidates in the Spring based on personal interviews and election statistics gathered by staffs.

One of the highlights of this process was the determination to support several promising newcomers. This is a departure from the procedure of many PACs, which chose to "play it safe" and not get involved with candidates with marginal chances for victory. I am pleased that FLAMPAC was successful with our new approach of selecting good candidates early and then targeting those in need for maximum assistance.

While 1980 was a good year, we can't afford to rest on our laurels. Congress and the Florida Legislature will be redistricting prior to the 1982 Elections, thus causing all members to be up for election in 1982 with many of them facing new constituencies and even running against another incumbent. The FLAMPAC Board is meeting in December to develop work programs and goals for the 1982 Elections. We will need the help and guidance of each of you if these challenges are to be met.

Thank you for your help this year!

*Francis C. Coleman, M.D.
President, Florida Medical
Political Action Committee
Tampa*



FMA AUXILIARY

School Health — A Shared Responsibility

"Focus on the Child" was the theme of the Florida School Health Conference held on October 29-31 in Orlando. Through the combined efforts of many sponsors, the Conference was designed to provide a working forum for school personnel, physicians, and private, voluntary, and official health personnel.

The following sponsors were responsible for the overwhelming success of the conference: The Florida P.T.A., Florida Dental Association, Florida Department of Education, Florida Department of Health and Rehabilitative Services, Florida Medical Association, Florida Medical Association Auxiliary, and the Florida Voluntary Health Association. There were opportunities through small group workshops and through presentations of nationally recognized experts to address issues, problems, and innovations related to school health.

I am extremely proud of the many, varied contributions to the Conference by the FMA Auxiliary members. As well as providing funds, we Auxilians were in charge of registration for the hundreds of participants and the faculty. Members from Orange County and Polk County handled this task. We presented the Early Bird Door Prizes on the first day of the Conference. Auxiliary members from throughout the state, including our State President, Anne Swing, supported the Conference with their attendance.

Bennie Spanjers, an FMA Auxiliary Past-President, served very effectively on the Legislative Panel with Ralph Turlington, Florida's Commissioner of Education. They addressed the issues of Legislation relating to School Health including the Comprehensive Health Education Act of 1973 and the School Health Services Act of 1974. These two State laws express a public commitment to school health that has made Florida a national leader in this field.

Our member, Anne Kremer from Lakeland, presented a very moving film, "Together on Main Street", which dealt very realistically with the current problems

of child abuse.

Issues pertinent to children living in Florida today were addressed both in general sessions and in small workshops at the Conference. Topics for study were Comprehensive Health Education Curricula, Dental Health, Nutrition Education, Parenting Education, Sex Education, Sports Medicine, Substance Abuse, School Health Services, School Health Advisory Committees, and Managing Health Education Programs.

Dr. T. Byron Thames, FMA President, addressed the General Session and left us with this timely thought: "One of America's most untapped resources is the minds and intellects of our children." The FMA plays a very important role as a member of the team to provide rational and flexible comprehensive health education for the children and youth of Florida. It aids schools with immunizations, health records, child abuse counseling, pre-school physicals, nutrition education, sports medicine, sex education counseling, and guidance in health-related careers. The Auxiliary also serves as a vital helpmate in these tasks.

The practice of healthful living is one of our basic survival skills. The importance of health education in schools cannot be overemphasized. The aim of health education is to teach children to make intelligent decisions about their own health. The knowledge and skills needed for good health are not easy to attain. However, learning is that part of living which so influences the child that he never gets over it. May we, as members of the FMA and the FMA Auxiliary, realize the importance of our roles as members of that team that shares the responsibility of presenting comprehensive health instruction to the children and youth of our state so they grow up into healthy and productive citizens.

*Mrs. Ben M. (Barbara) Crowder
FMAA Health Education Chairman
Winter Haven*



"NOW OUR BUSINESS IS AS GOOD AS OUR PRACTICE."

We're physicians. But we're also business people. That's why our group practice has a business manager.

It takes a lot of work to manage all the business details of a growing practice like ours. That's why we have BASMED. It cuts work and handles the details.

That makes everything a lot easier. Like insurance processing. With BASMED we do little more than enter the name, date, and procedure for each patient. BASMED fills in the rest from its vast electronic files. It prints the forms for the right insurance companies, ready for mailing.

And since we're in Florida, BASMED can transmit our claims information by telephone directly to the Blue Cross/Blue Shield computer. This way, our claims are pro-

cessed almost instantly. Not only that, but the turnaround time on our money is a matter of days, not weeks.

BASMED makes short work of administrative tasks too—like balancing daily receipts and charges. And it generates periodic reports at the touch of a button. For example, if we want information on account aging, total dollars and units by procedure, charges by doctor, or insurance claims aging, BASMED puts it right in our hands.

The result is a more efficient office and improved cashflow. In fact, BASMED does its job so well that we hardly know it's there.

But our business manager does. And our office staff does. They're very happy with BASMED.

That makes *us* happy.

And that means we *all* do a better job.

For more information on how to give your practice the business, write or call:

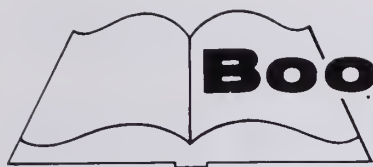
Medoc Computer Systems, Inc.
666 Sixth Street South
Suite 103
St. Petersburg, Fla. 33701
(813) 894-1459

BASMED

The Medical
Business System



medoc
Computer Systems



Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

Clinical Therapeutics, Special Issue on Cefoperazone Sodium: Proceedings of the First International Symposium, Boston, October, 1979, Chaired by Dr. Harold Neu and Dr. Yasushi Ueda. 208 Pages. Price \$26/year for four issues. Excerpta Medica, Inc., Princeton, New Jersey, 1980.

This issue of *Clinical Therapeutics* is a special issue, one of four published yearly. There is a symposium of various investigation studies and manuscripts with reviews by Dr. Harold Neu and Dr. Yasushi Ueda. Included are studies comparing bacterial sensitivities, comparison with other antibiotics, pharmacokinetics, and actual evaluation in clinical practice. A voluminous amount of therapeutic and clinical data is presented. This book is certainly not for the casual peruser. Infectious diseases specialists would find it acceptable.

Cefoperazone sodium reported on is a third generation semisynthetic cephalosporin with an extremely broad antibacterial spectrum covering most gram positives and gram negatives. It has a relatively long half life of approximately two hours, allowing twice a day dosing. It is administered parenterally and it is distributed well through most body tissues with lower concentrations in lung, muscle, and eye. CSF levels are not thoroughly evaluated but appear to be therapeutic for some organisms. It is 90% serum bound. Its principal mode of excretion appears to be the liver with adequate urine levels for antibiotic therapy. Accumulation may occur in patients with liver disease. The dosage is not altered for renal disease. Side-effects at this time appear to be minimal but adequate clinical experience is not available to determine this.

Its major contribution is the excellent sensitivity against *Pseudomonas aeruginosa* as well as most other gram negatives with the exception of *Acinetobacter*, some *Serratia*, and variable results against *Bacteroides fragilis*. It shows synergism with tobramycin against *Pseudomonas*.

In summary, the extremely enthusiastic tone of the major author, Dr. Neu, is not completely supported by the published data of clinical trials. However, the drug, in many ways, may be the answer to the dream of a rela-

tively safe drug for treating an unknown bug in an unknown location with minimal clinical data. (A shotgunner's dream.)

Earl H. Eye Jr., M.D.
Jacksonville

Dr. Eye is engaged in the private practice of internal medicine in Jacksonville with subspecialties of pulmonary and infectious diseases.

Mechanics of the Mind by Colin Blakemore. Illustrated. 208 Pages. Price \$24.50 (\$7.50 paper). Cambridge University Press, 1977.

The dynamite that sent a 13 pound tamping iron through the skull of Phenius P. Gage in 1848 was also responsible in part for the explosion that followed in our understanding of the brain and how it works. The fact that Mr. Gage lived for many years after the accident is remarkable but the rapid advances in brain research that followed are even more intriguing, and Colin Blakemore has recorded the historical and scientific advances without neglecting some of man's earliest thoughts on the mind and its relationship to the body as well as to a living cosmos.

Just as Kenneth Clark presented *Civilization* to us and Jacob Bronowski gave us *Ascent of Man*, Colin Blakemore has greatly expanded on his Reith Lectures (BBC) to bring us this truly remarkable book. Recognized as the winner of the 1978 Phi Beta Kappa Award in Science, the book is indeed much more than science for it is interwoven with history, philosophy, psychology, and sociology in the skillful way that is known only to the artist.

The titles of the six lectures that constitute the book should be enough to compel the reader to buy it for his permanent library. For example: The Divinist Part of Us, Chuang Tzu and the Butterfly and Madness and Morality. On reading it, my response was like the poet's (Keats) who wrote *On First Looking Into Chapman's*

Homer, and having shared it personally with the author, I offer it to you . . .

After Reading Blakemore's Book

I find I am haunted by this book and feel
In closer contact with my soul since reading that
"The right hemisphere whispers softly to the left",
And yet, somehow, I've known it all along, and still
Enjoy certain lapses into another realm that Plato must
Have sought in fathoming immeasurable depths beyond
His ken.

It makes for a whole new freedom, too, made somehow
Safer by aeons of genetic wars still raging that
Shut out the usual din of our clock-bound universe, and
Thereby makes me part of all that has been or will be in a
Never-ending conversation with the sun, the moon and
Stars and all that makes up this fascinating firmament.

*Matthew E. Morrow, M.D.
St. Augustine*

Dr. Morrow is retired from the practice of internal medicine in Jacksonville and currently lives in St. Augustine. Dr. Morrow became acquainted with the author while serving as Host Dean for an Institute on International Law at Oxford. Dr. Morrow's first poems were published in 1936, and one is scheduled to appear shortly in *The American Scholar*.

Books Received

Receipt of the following books is acknowledged.

Microbial Diseases — Notes, Reports, Summaries, Trends compiled by Carl W. May. 322 Pages. Paperback. Illustrated. William Kaufmann, Inc., Los Altos, California, 1980.

Sound Sleep by Quentin R. Regestein, M.D. 208 Pages. Illustrated. Price \$10.95. Simon and Schuster, New York, 1980.

Current Obstetric and Gynecologic Diagnosis and Treatment by Ralph C. Benson, M.D. 1001 Pages. Illustrated. Paper. Price \$21.00. Lange Medical Publications, Los Altos, California, 1980.

Consumer's Guide to Cosmetics by Tom Conry. 376 Pages. Illustrated. Paper. Price \$3.95. Doubleday & Company, Inc., New York, 1980.

Mesmerism, A Translation of the Original Medical and Scientific Writings of F. A. Mesmer, M.D. 180 Pages. Price \$11.50. William Kaufmann, Inc., Los Altos, California, 1980.

The Human Patient by Naomi Remen, M.D. 264 Pages. Price \$10.95. Anchor Press, New York, 1980.

The Doctors' Case Against the Pill by Barbara Seaman. 239 Pages. Paper. Price \$6.50. Doubleday & Company, Inc., New York, 1980.

Every Woman's Health, The Complete Guide to Mind and Body edited by D. S. Thompson, M.D. 776 Pages. Illustrated. Price \$19.95. Doubleday & Company, Inc., New York, 1980.

Sex by Prescription by Thomas Szasz. 198 Pages. Price \$10.95. Doubleday & Company, Inc., New York, 1980.

Dangerous Marine Animals That Bite, Sting, Shock, Are Non-Edible by Bruce W. Halstead, M.D. 208 Pages. Illustrated. Price \$15.00. Cornell Maritime Press, Inc., Centreville, Maryland, 1980.

Atlas of Bedside Procedures edited by Thomas J. Vander Salm, M.D. 408 Pages. Illustrated. Price \$18.95. Little Brown and Company, Boston Massachusetts, 1980.

Legal Rights of Asbestos Exposure Victims by Roman M. Silberfeld and Richard L. Hecht. 14 Pages. Silberfeld and Hecht, Los Angeles, 1980.

MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

FEBRUARY

6th Annual Review and Recent Practical Advances in Pathology, Feb. 1-6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Being an Effective Clinical Teacher, Feb. 2-6, Keystone, Colorado. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Florida Mid-Winter Seminar in Ophthalmology, Feb. 2-5, Doral Beach Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Cardiology at Walt Disney World, Feb. 5-8, Contemporary Resort Hotel, Lake Buena Vista. For information: Harold L. Greenberg, M.D., c/o AHA, Central Florida, P.O. Box 6665, Orlando 32853.

Florida Mid-Winter Seminar in Otolaryngology, Feb. 6-8, Doral Beach Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

John T. Dickinson Annual Symposium: Advanced Facial Plastic and Reconstructive Surgery, Feb. 6-8, Holiday Inn Oceanside, Vero Beach. For information: Facial Surgery Symposium, Ferdinand F. Becker, M.D., 777 37th Street, Suite C-101, Vero Beach 32960.

1981 Update in OB/GYN, Feb. 9-11, Disney World, Lake Buena Vista. For information: Frank Riggall, M.D., Department of OB/GYN, Box J-294, University of Florida College of Medicine, Gainesville 32610.

Conference on the Beach, 2nd Annual Family Practice Update, Feb. 16-21, Daytona Hilton, Daytona Beach. For information: Richard W. Dodd, M.D., Halifax Hospital Medical Center, Box 1990 Daytona Beach 32015.

"Non-Radical Surgical Treatment of Breast Cancer; Advances in Systemic Treatment", Feb. 17, Martin Memorial Hospital, Stuart. For information: Donald R. Cox, M.D., 1001 East Ocean Boulevard, Stuart 33494.

Florida Symposium on Micronutrients in Human Nutrition, Feb. 17-18, University of Florida, Gainesville. For information: James R. Kirk, Chairman, Food Science and Human Nutrition Department, University of Florida, Gainesville 32611.

Medical Update 1981, Feb. 18-20, Education Center, South Miami Hospital, South Miami. For information: Leonard Zwerling, M.D., c/o Continuing Education, South Miami Hospital, 7400 S.W. 62nd Avenue, South Miami 33143.

Stress and Chemical Dependency — Strategies for the 80's, Feb.

19-22, The Breakers, Palm Beach. For information: Jose Almeida, M.D., Medical Director, Daryl Kosloske, Executive Director, 1014 N. Olive Avenue, West Palm Beach 33401.

5th Annual Cardiovascular Symposium — "Atherosclerotic Coronary Heart Disease — Selected Topics", Feb. 20-21, Sheraton Sand Key, Clearwater Beach. For information: Donald R. Eubanks, M.D., 323 Jeffords Street, P.O. Box 299, Clearwater 33517.

Teaching Conference in Clinical Cardiology, Feb. 25-28, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Sixth Annual Midwinter Seminar in OB/GYN, Feb. 26-28, St. Petersburg Beach. For information: James M. Ingram, M.D., Department of OB/GYN, Box 18, College of Medicine, University of South Florida, Tampa 33612.

Pediatric Dermatology Seminar VIII, Feb. 26-Mar. 1, Eden Roc Hotel, Miami Beach. For information: Guinter Kahn, M.D., Suite 401, 16800 N.W. 2nd Avenue, North Miami Beach 33169.

Cardiac Ischemia and Arrhythmias: Current Concepts for Diagnosis & Treatment, Feb. 27-Mar. 1, Bahia Mar Hotel, Ft. Lauderdale. For information: Stephen E. Mattingly, 64 Inverness Drive, East, Englewood, Colorado 80112.

Internal Medicine 1981 (16th Annual Postgraduate Course), Feb. 28 - Mar. 6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

MARCH

Being an Effective Clinical Teacher, Mar. 2-6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Comprehensive Review in Basic Neurology for Psychiatrists and Generalists, Mar. 2-6, Konover Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Postgraduate Medical Refresher Course, Mar. 2-13, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Donald R. Lannin, M.D., 832 Central Medical Building, St. Paul, Minnesota 55104.

Internal Medicine Update '81, Mar. 2-7, Dutch Resort Hotel, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1414 S. Kuhl Ave., Orlando 32806.

Issues in the Psychotherapy of Women, Mar. 5, Williamson's

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient
**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule
contains:

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Restaurant. For information: Peggy Jackson, ACSW, 330 S.W. 27th Avenue, Ft. Lauderdale 33315.

Developmental Disabilities and Pediatric Practice, Mar. 5-7, Sheraton and Sand-Key Hotel, Clearwater Beach. For information: Mary G. Tenne, AAP, P.O. Box 1034, Evanston, Illinois 60204.

Oculoplastic-Orbital Update, Mar. 5-7, University of South Florida College of Medicine, Tampa. For information: James A. Rush, M.D., Box 21, 12901 N. 30th Street, Tampa 33612.

Problems in Rheumatology, Mar. 11-14, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bernard F. Germain, M.D., Assistant Professor of Medicine, Director, Division of Rheumatology, Box 19, University of South Florida College of Medicine, 12901 North 30th Street, Tampa 33612.

Postgraduate Seminar in Dermatology, Mar. 12-14. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Orthopaedics for Family and Emergency Physicians, Mar. 18-21, Royal Plaza Hotel, Lake Buena Vista. For information: Allan W. March, M.D., Box J-222, JHM Health Center, Gainesville 32610.

Infectious Disease and Chemotherapy for the Practicing Physician 1981, Mar. 19-21, Dutch Resort Hotel, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1414 S. Kuhl Avenue, Orlando 32806.

Pediatric Orthopaedics for Family Practitioners and Pediatricians, Mar. 22-25, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

American and European Views on Anesthesia, Mar. 22-27, Zermatt, Switzerland. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Current Clinical Concepts in Otolaryngology (in English and Spanish), Mar. 23-25, Eden Roc Hotel, Miami. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Postgraduate Course on Pediatric Orthopaedics for Family Practitioners and Pediatricians, Mar. 23-25, Sheraton Bal Harbour, Hotel, Miami Beach. For information: Anthony Ballard, M.D., Course Chairman, Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Box 016960, Miami 33101.

Toxic and Metabolic Liver Injury, Mar. 26, University of South Florida Medical Center, Tampa. For information: H. Worth Boyce, M.D., 12901 N. 30th Street, Box 19, Tampa 33612.

12th Annual Topics in Internal Medicine, Mar. 26-28, Gainesville Hilton, Gainesville. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Pan American Symposium on Trauma of Head and Neck (in English and Spanish), Mar. 26-28, Eden Roc Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



"An International Conference on Gerontology", Mar. 29-Apr. 3, Sheraton Bal Harbour Hotel, Miami Beach. For information: Office of Planning, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140.

Oncology in General Practice, 2nd Annual Conference, Mar. 30-Apr. 8, Aboard SS. Doric in the Caribbean Sea. For information: Peter W. A. Mansell, M.D., Comprehensive Cancer Center D8-4, University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

APRIL

Hypertension and Cardio-renal Function in the Elderly, Apr. 2-3, Konover Hotel, Miami Beach. For information: Barry J. Materson, M.D., 1201 N.W. 16th Street, Miami 33125.

Clinical Management of Coronary Disease & Exercise Testing, Apr. 3-5, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive, East, Englewood, Colorado 80112.

Comprehensive Review Course: ECFMG, VQE, and FLEX (in Spanish), Apr. 6-July 17, UM/Jackson Memorial Hospital, Miami. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Critical Care Medicine '81, Apr. 9-11, Dutch Resort Hotel, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1414 S. Kuhl Ave., Orlando 32806.

Atrial and Ventricular Arrhythmia Management Update, Apr. 16-18, Belleview Biltmore, Clearwater. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

MAY

ECG Interpretation and Arrhythmia Management, May 8-10, Don Cesar Hotel, St. Petersburg. For information: Stephen E. Mattingly, 64 Inverness Drive, East, Englewood, Colorado 80112.

Human Sexuality, May 14-16, Gainesville Hilton, Gainesville. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Personality Adaptation Theory Used in Working With Couples and Families, May 22, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Fort Walton Beach 32548.

Master Approach to Cardiovascular Problems, May 29-31, The Contemporary Hotel, Walt Disney World, Lake Buena Vista. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

JUNE

13th Family Practice Review, June 22-26, The Breakers, Palm Beach. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, (7th Annual Review Course), Aug., Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

A peripheral vasodilator

for treatment of
**leg cramps
cold feet
tinnitus
discomfort on
standing**

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



THE AMERICAN SOCIETY OF CONTEMPORARY MEDICINE AND SURGERY

March 15-21, 1981

Sheraton Twin Towers Hotel — Orlando, Florida

Accreditation: Up to 45 credit hours in Category I (ASCMS — AMA — AOA 2-D)

AAFP — 49 Prescribed Hours by the American Academy of Family Physicians

- Sunday, March 15** **SPECIAL FEATURE: COSMETIC SURGERY SEMINAR.** Pierre Guibor, M.D., Chairman.
- Monday, March 16** **WHAT'S NEW IN MEDICINE.** Michael E. DeBakey, M.D., Chairman; Ernest C. Borden, M.D.; Jacques R. Caldwell, M.D.; George C. Crile, Jr., M.D.; Michael E. DeBakey, M.D.; David L. Horwitz, M.D.; Ruth Jackson, M.D.; Joseph L. Melnick, Ph.D.; Frederick K. Merkel, M.D.; Richard R. Miller, M.D.; George R. Prout, Jr., M.D.; Phillip P. Toskes, M.D.; Max Samter, M.D.; Ronald J. Scott, M.D.; Arnold N. Weinberg, M.D.; Morris Notelovitz, M.D.
- Tuesday, March 17** **PULMONARY DISEASES.** Kenneth F. MacDonnell, M.D., Chairman; P. Bailey Francis, M.D.; Stephen J. Jay, M.D.; E. Clinton Lawrence, M.D.; Gary H. Lyman, M.D.; Kenneth F. MacDonnell, M.D.; Ronald J. Scott, M.D.; Maurice Segal, M.D.; William A. Speir, Jr., M.D.; James K. Tennenbaum, M.D.; Arnold N. Weinberg, M.D.; Roger B. Wigton, M.D.
- Wednesday, March 18** **CANCER.** R. Lee Clark, M.D., Chairman; Ernest C. Borden, M.D.; Devron H. Char, M.D.; R. Lee Clark, M.D.; George C. Crile, Jr., M.D.; Charles L. Cusumano, M.D.; Robert B. Golbey, M.D.; Gary H. Lyman, M.D.; Ralph C. Marcove, M.D.; George R. Prout, Jr., M.D.; Richard Stein, M.D.
- Thursday, March 19** **ARTHRITIS — RHEUMATOLOGY.** Andrei Calin, M.D., Chairman; Roy D. Altman, M.D.; Andrei Calin, M.D.; Jacques R. Caldwell, M.D.; L. R. Espinoza, M.D.; Bernard F. Germain, M.D.; David S. Howell, M.D.; Ruth Jackson, M.D.; John H. Talbott, M.D.
- Friday, March 20** **HYPERTENSIVE DISEASES.** John H. Laragh, M.D., Chairman; Frank A. Finnerty, M.D.; Norman M. Kaplan, M.D.; John H. Laragh, M.D.; Thomas C. Marbury, M.D.; Peter J. Sones, M.D.; Dana L. Shires, M.D.

Workshop and Tutorial Courses

Fee: \$75 each CME 4 Hours, Category I

Monday 2:00 - 6:00 p.m. One Day Course
DISORDERS OF THE CERVICAL SPINE

Monday 2:00 - 6:00 p.m. One Day Course
PRACTICAL PULMONARY MEDICINE

Monday, 2:00 - 6:00 p.m. One Day Course
Tutorial Course
OLD AND NEW WAYS
OF TREATING OBESITY

Tuesday, 2:00 - 6:00 p.m. One Day Course
CURRENT CONCEPTS AND NEW
DEVELOPMENTS IN THE DIAGNOSIS
AND TREATMENT OF PANCREATITIS

Tuesday, 2:00 - 6:00 p.m. One Day Course
OFFICE GYNECOLOGICAL PROCEDURES
FOR A GENERAL PRACTITIONER

Wednesday, 2:00 - 6:00 p.m. One Day Course
PRACTICAL ASPECTS OF THE OFFICE
MANAGEMENT OF DIABETES

Thursday, 2:00 - 6:00 p.m. One Day Course
MANAGEMENT OF COMMON ARTHRITIS

Friday, 2:00-6:00 p.m. One Day Course
MANAGING COMMON THYROID DISEASES

Medical Board Review Courses

Monday, March 16
CARDIOVASCULAR DISEASE

Tuesday, March 17
INFECTIOUS DISEASES; ANTIBIOTICS

Wednesday, March 18
IMMUNOLOGY AND ALLERGY

Thursday, March 19
ENDOCRINE DISEASES;
METABOLIC DISORDERS

Friday, March 20
NEPHROLOGY;
HEMATOLOGY

REGISTRATION FORM

American Society of Contemporary Medicine and Surgery
16th Annual Meeting and Scientific Assembly

Dr. _____

Address _____

Membership dues: \$60

Meeting admission:

	Members	Nonmembers	Residents
Preregistered	\$250	\$325	\$75 with letter from
At door	\$300	\$375	department chairman
Board Review			
Courses — 6 days	\$250		

Tutorial(s) _____
(fees additional)

☐ Check ☐ Master Charge ☐ VISA

Card No. _____ Exp. Month _____ Year _____

Make check payable to:

AMERICAN SOCIETY OF CONTEMPORARY MEDICINE AND SURGERY
6 North Michigan Avenue, Chicago Illinois 60602

No refunds after February 1, 1981

For Registration and Information:

call 800-621-0463, or in Illinois, call 312-782-7888.

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

PRIMARY CARE and subspecialty physicians to join multispecialty group in South Palm Beach County. Excellent facilities. Compensation includes possibility of ownership in P.A. Send CV to Post Office Box 23606, Oakland Park, Florida 33334.

WANTED — Family Practitioner or Internist, Board qualified or Certified, to associate with two Certified Family Physicians in Coral Gables. Eventual partnership. H.M. Silberman, M.D., (305) 443-3001.

WANTED: OPHTHALMOLOGIST, INTERNAL MEDICINE, FAMILY PRACTITIONER, or PEDIATRICIAN to complement 14 other professionals in busy South Florida building. Write A. Mitchell, 3070 N.E. 47th Street, Fort Lauderdale, Florida 33308, phone (305) 772-2200.

WANTED / ONCOLOGIST. Central Florida, Excellent Opportunity. Please send C.V. to C-1022, Post Office Box 2411, Jacksonville, Florida 32203.

DELRAY BEACH — No refraction or contact lens fitting. Prefer glaucoma specialist. Salary and terms negotiable. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

CENTRAL FLORIDA — Experience G.P., F.P., or E.R. Physician. Very competitive salary. Weekdays only — opportunity for stock participation. Reply: Medical Director, 9893 Lake Georgia

Drive, Maitland, Florida 32751. Phone: (305) 647-7170.

FLORIDA: Immediate position — mature F.P./E.R./Internist for minor ER/Industrial Medical Clinic in Orlando Florida area. Salary negotiable, stock options available. Reply to: Medical Director, 9893 Lake Georgia Drive, Maitland, Florida 32751.

WEST FORT LAUDERDALE AREA — Internist-Cardiologist with 2,500 square foot office to share in medical building adjacent to hospital, within 15 minutes of three other hospitals; option to share medical equipment. Reply C-1024, Post Office Box 2411, Jacksonville, Florida 32203, or phone during office hours (305) 583-0949.

RADIOLOGIST NEEDED for multispecialty group in the Florida Keys. Send curriculum vitae to Andrew J. Wolszczak, M.D., 8151 Overseas Highway, Marathon, Florida 33050.

LOVELY SOUTHWESTERN CLIMATE — multispecialty group seeking OB-GYN physician. Substantial guarantee. Contact Talton Francis, El Paso Medical-Surgical Associates, P.A., 10301 Gateway West, El Paso, Texas 79925.

CARDIOLOGIST needed immediately to join expanding internal medicine practice. BC/BE. All facilities for non-invasive cardiology. Beautiful southwest Florida near Ft. Myers. Terms negotiable. Apply C-1025, Post Office Box 2411, Jacksonville, Florida 32203.

LOVELY SOUTHWESTERN CLIMATE — multispecialty group seeking anesthesiologist. Substantial guarantee. Contact Talton Francis, El Paso Medical-Surgical Associates, P.A., 10301 Gateway West, El Paso, Texas 79925.

MOORE HAVEN, Glades County (on Lake Okeechobee) — Immediate need for Family Practitioner to live in Moore Haven; population 2,000; hospitals 25 and 45 miles away. Agricultural community with new industry moving in. Health department being only medical facility. Excellent fishing and hunting. Please contact: Walter C. McCants, RPH, P.O. Box 951, Moore Haven, Florida 33471. Phone (813) 946-1212. 9-5:30 p.m.

Situations Wanted

BOARD CERTIFIED PREVENTIVE MEDICINE SPECIALIST: Florida licensed, in early 30's with more than 5 years experience in large Eastern health organization, seeks administrative / executive health position in large Florida health agency, insurance, or industrial corporation. Reply C-993, Post Office Box 2411, Jacksonville, Florida 32203.

PULMONARY INTERNIST, ABIM, University trained all phases of pulmonary medicine, seeks practice position, available July 1981. Reply Clifford Benezra, M.D., 15911 Godwin Court, Fountain Valley, California 92708. (714) 775-0142.

GENERAL, COLON AND RECTAL Surgeon; Board Certified in both; Spanish speaking; U.S. trained; seeking relocation. Solo, partnership or group. Available 30 days notice. Please reply to Luis F. Zamora, M.D., 923 Reseda, Houston, Texas 77062.

UROLOGIST, 30, American graduate, Board eligible. Excellent training at large New York City Medical Center. Available July, 1981. Seeks group practice or partnership. Call (212) 876-5175.

PATHOLOGIST — Experienced general Pathologist with Florida license desires challenging position. Anatomic and Clinical Pathology Boards with subspecialty boards in chemical and radioisotopic pathology. Experience and interest in Forensic Pathology. Reply: C-1017, P.O. Box 2411, Jacksonville, Florida 32203.

GASTROENTEROLOGIST, ABIM, completing university training. Desires practice opportunity. Available July, 1981. Dr. M. Freedman, 6351 Lebanon Avenue, Philadelphia, PA 19151. (215) 662-8477.

CARDIOLOGIST - INTERNIST, 29, Board Certified, excellent skills noninvasive and invasive Cardiology. Seeks solo, partnership or hospital based practice. Available summer '81. Please contact Rao Musunuru, M.D., 354 Henry St., Apt. 2, Brooklyn, N.Y., 11201. Telephone (212) 596-2986.

BOARD CERTIFIED ALLERGIST. University trained. Solo practice 15 years. Wishes to relocate. Florida group, VA, or association. Practice adult and pediatric allergy. Ready to move. Reply C-1023, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST-CARDIOLOGIST FMG 32, interested in solo, partnership or hospital based practice, willing to do non-invasive cardiology and internal medicine. Available immediately. Reply C-1026, P.O. Box 2411, Jacksonville, Florida 32203.

UROLOGIST, 30, American graduate, AOA, excellent training at NYC university medical center, adult/pediatric urology, Florida license, available July 1981; seeks group or solo practice, all areas. Reply C-1003, P.O. Box 2411, Jacksonville, Florida 32203.

OB/GYN — Boards, Florida license, wants to work a few hours per day. Any capacity as surgical assistant, consultation, locum tenens, etc., except deliveries. Call before January 15. (618) 465-7250; after (813) 867-4382 — St. Petersburg area.

GENERAL, COLON AND RECTUM SURGEON, trained in Colonoscopy, Board eligible, 35, seeks position in Florida to practice either one specialty or both. Speaks Spanish fluently. Available October 1981. Contact: Luis F. Espallat, M.D., 1517 Texas Avenue, Homestead AFB, Florida 33039. Phone (305) 257-2870.

RETIRED — 1978 General Practitioner desires part time General Medicine in Palm Beach County area. Graduate University of Buffalo, N.Y., 1932. Reply C-1027, P.O. Box 2411, Jacksonville, Florida 32204.

LOCUM TENENS, COMP-HEALTH. Our medical group can place a well-qualified physician in your practice during your absence. For more information call or write: Comprehensive Health Systems, Inc., 175 West Second South, Salt Lake City, Utah 84101. (801) 532-1200.

Practices Available

FOR SALE: Established Family Practice office and equipment in growing community in Lake Okeechobee area, near West Palm Beach. Lovely home also available. Call collect (305) 924-5281 or (305) 683-6910.

GENERAL PRACTICE for sale or possible association. Same location 20 years. Best area Pinellas County. Dr. Gonzalez (813) 443-2104 after 7 p.m.

GENERAL PRACTICE FOR SALE — Established general practice in lucrative area of Southwest Florida; building two years old, fully furnished and equipped. Practice and office suitable for two doctors. Office based practice retiring. Contact C-1019, P.O. Box 2411, Jacksonville, FL 32203.

DERMATOLOGY PRACTICE — for sale: fully equipped and furnished, old, well established in Miami. Very easy terms. Phone (305) 753-1293.

MEDICAL OFFICE for sale; fully furnished and equipped. Excellent location in rapidly growing area. Contact Lee County Medical Society, P.O. Box 1704, Fort Myers, Florida 33902.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

DURANGO, COLORADO: Magnificent 35 to 40 acre Ranchsites on 2,000 acre ranch. Only a few left. From \$3,000 per acre. Will finance. Incredible hunting on property. Year 'round recreation, fabulous skiing. Russell Yates, Beaver Creek Ranch, P.O. Box 2433, Durango, Colorado 81301. Telephone (303) 259-2680.

MEDICAL SUITES, West Palm Beach. Sized and built to need. Adjoining Community Hospital of Palm Beaches. Community Professional Building, 2151 45th Street, (305) 842-5023.

PALM BAY, FLORIDA: Space Available in new "Port Malabar Professional Center". Opening in summer, 1981. South Brevard County is booming with new business, families, and opportunities. Now with preconstruction prices and free custom designing. Call Donald L. Kane, D.D.S., Phone (Business) (305) 773-6666, (Home) (305) 254-3694.

WITHLACOOCHIE RIVER Heavily wooded half acres of swift running clean water, Gulf access. Exclusive area, first time offered. Vacation now, retire later. Pictures available. Contact Lona Lubin, Century 21, We Realty, Inc., 777 Pasadena Avenue South, St. Petersburg, Florida 33707. (813) 381-0303 or (813) 343-0680.

BRECKENRIDGE, COLORADO, 2 bedroom, two bath, luxury condo now renting for 1980-81 ski season. Ski-in. Dale Davis, M.D. (305) 836-0121.

ORLANDO: For rent, two offices 1,300 and 2,000 sq. feet in medical building with four other specialists at 6003 Silver Star Road. Excellent location, near Brookwood Hospital. Telephone (305) 295-4644.

Equipment

FOR SALE — Olympic Fiberoptic Bronchoscope, used two times. All attachments. Excellent condition. \$3,000 firm. Contact L. C. Taylor, M.D., 320 Parkview Place, Lakeland, Florida 33801. Phone (813) 682-4913.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Col, 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.



American Medical Association
**PHYSICIANS' PLACEMENT
SERVICE**

LOOKING FOR A PLACE TO PRACTICE?

If you're seeking a practice opportunity, the AMA's Physicians' Placement Service is the best source of information on positions available. Because the listings cross geographic and specialty lines, the AMA's Physicians' Placement Service is the largest and most comprehensive in the field.

Published quarterly, the **Opportunity Placement Register** lists thousands of openings indexed by specialty, type of practice, date of availability, financial arrangements, location and size of community, etc.


The companion **Physician Placement Register** contains your coded resume and is sent to communities, clinics, hospitals, corporations, and others seeking the services of a physician providing you with important additional exposure.

For further information and a copy of the current **Opportunity Placement Register**, write:

AMA Physicians' Placement Service
535 N. Dearborn Street, SJ
Chicago, Illinois 60610

Remember
ZYLOPRIM[®]
the original (allopurinol)
100 and 300 mg
Scored Tablets

The name
Zyloprim
is now
imprinted on
each tablet.

 **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

When
impotence
is due to androgenic deficiency.

Android[®] 5^{Buccal} / 10^{Oral} / 25^{Oral}
Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy When androgen deficiency is the cause of male climacteric/eunuchoidism, eunuchism/post-pubertal cryptorchidism.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism; 2. Male climacteric symptoms when these are secondary to androgen deficiency; 3. Impotence due to androgenic deficiency; 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg; Postpubertal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., J. B. Sipahoglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

Write for new double blind study reprints and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Advertisers

American Society of Contemporary Medicine and Surgery Meeting	70	Eli Lilly & Company Keflex	6
Abbott Laboratories Meeting	4	Medoc Computer Systems Service	64
Boots Pharmaceutical Ru-Tuss	18a	Morton Plant Hospital Meeting	18
Brown Pharmaceuticals Cerebro-Nicin	68	Roche Laboratories Librax	18a
Lipo-Nicin	69	Valium	2
Android	73	Bactrim	75-6
Burroughs Wellcome Zylprim	73	Institutional	17
Empirin \bar{c} Codeine	18a	Limbitrol	58a
Ciba-Geigy Corporation Transderm-V	58a	Smith Kline and French Dyazide	58a
Convention Press Service	12, 58	University of Miami Meetings	3, 15, 60
Florida Medical Foundation Citrus and Seafood	53	U.S. Army Recruitment	57
Geriatric Pharmaceutical Co. Iso-Bid	8	Willingway Hospital Service	16
Janssen Pharmaceuticals Vermox	14	Wyeth Laboratories Cyclapen	12, 13
		Ativan	58a

Florida Medical Association Officers and Council Chairmen

Officers

T. Byron Thames, M.D., Orlando, President
Sanford A. Mullen, M.D., Jacksonville, President-Elect
Gerold L. Schiebler, M.D., Gainesville, Vice President
James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
Robert E. Windom, M.D., Sarasota, Secretary
J. Russell Forlaw, M.D., Boynton Beach, Treasurer
Richard S. Hodes, M.D., Tampa, Immediate Past-President
W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation and Regulations
William W. Thompson, M.D., Ft. Walton Beach, Health Care Financing
Joseph T. Ostroski, M.D., Miami, Medical Services
Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
Dick L. Van Eldik, M.D., Lake Worth, Specialty Medicine

Announcing a major symposium for primary care physicians

Anxiety: the therapeutic dilemma



National authorities offer views and insights

Are minor tranquilizers overused? Is anxiety overdiagnosed? Do anti-anxiety drugs create other clinical problems? What are the alternatives?

These and other critical questions will be examined in a one-day symposium and workshop at the Tulane Medical

Center, New Orleans, on February 14, 1981. Eminent physicians will discuss aspects of treatment including (1) recognition and management of the dependence-prone patient, (2) ways to minimize tranquilizer dependency, (3) current information on the biochemistry of anxiety and (4) how it can

affect treatment modalities.

Unique interactive format offers direct participation Filmed case presentations provide source material for participant interaction — to demonstrate keys to differential diagnosis and clarify guidelines for selecting appropriate drug and non-drug therapies.

Program Topics and Faculty

The Clinical Spectrum of Anxiety

Michael J. Halberstam, MD, Private Practice, Internal Medicine and Cardiology, Washington, DC; Editor, Modern Medicine; Associate Clinical Professor of Medicine, George Washington University Medical Center

Anxiety: Etiology and Dynamics

Sidney L. Werkman, MD, Professor of Psychiatry, University of Colorado School of Medicine

Differential Diagnosis of Anxiety

Robert E. Rakel, MD, Professor and Head, Department of Family Practice, The University of Iowa College of Medicine

The Problem of Drug Dependence

David H. Mielke, MD, Associate Professor of Psychiatry, Tulane University School of Medicine

Pharmacology and Pharmacokinetics of the Minor Tranquilizers

Leo E. Hollister, MD, Professor of Medicine, Psychiatry and Pharmacology, Veterans Administration Medical Center and Stanford University School of Medicine

Benzodiazepine Receptors

Solomon H. Snyder, MD, Chairman & Professor, Department of Neuroscience, Distinguished Service Professor of Neuroscience, Psychiatry and Pharmacology, The Johns Hopkins University School of Medicine

Management Approaches to the Patient With Anxiety

Julius Michaelson, MD, Past President, American Academy of Family Physicians

Tranquilizers: Guidelines for Appropriate Use

Robert E. Rakel, MD, Professor and Head, Department of Family Practice, The University of Iowa College of Medicine

Non-Drug Treatment Alternatives

Sidney L. Werkman, MD, Professor of Psychiatry, University of Colorado School of Medicine

Other members of the symposium faculty, from the Tulane University School of Medicine, include John W. Goethe, MD and Daniel K. Winstead, MD.

Eight credit hours in Category 1 for PRA/AMA, Prescribed hours by AAFP, Category 2-D of AOA and/or Formal Learning cognates of ACOG will be awarded.

Anxiety: The Therapeutic Dilemma is being produced in collaboration with Tulane University School of Medicine, Department of Psychiatry and Neurology by M.E.D. Communications, under an educational grant from Abbott Laboratories.

Office of Continuing Education, Tulane Medical Center,
1430 Tulane Avenue, New Orleans, Louisiana 70112.

Please send full information about the symposium
Anxiety: The Therapeutic Dilemma.

Name

(please print)

Title

Address

City

State

Zip

0013382

0-0571

A



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.


Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

 Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

MASTER APPROACH TO CARDIOVASCULAR PROBLEMS

Ninth Annual Conference

At

The Contemporary Hotel
Walt Disney World Resort Complex
Orlando, Florida
May 29 - 31, 1981

Guest Speakers:

Robert S. Eliot, M.D.
Mark E. Josephson, M.D.
Dennis Krikler, M.D.

University of Miami Faculty:

Agustin Castellanos, M.D.,
Bernard Fogel, M.D.,
Louis Lemberg, M.D., and
Robert J. Myerburg, M.D.

(For more information please call (305) 325-6411 or complete coupon and mail to: Y. Barcena, Cardiology (D-39), University of Miami School of Medicine, P. O. Box 016960, Miami, Florida 33101).

Please send me more information regarding
"MASTER APPROACH TO CV PROBLEMS"

Name _____

Phone () _____

Address _____

Valium®
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

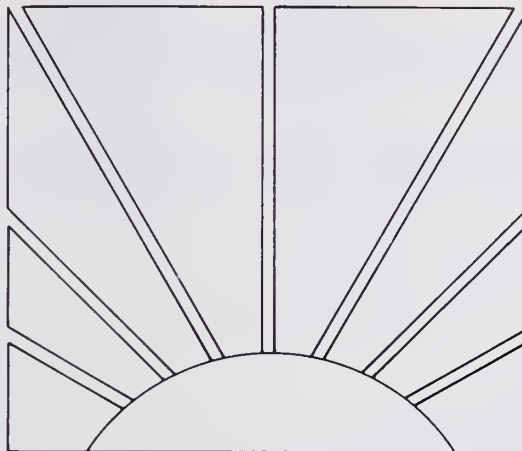
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication. abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
© Nutley, New Jersey 07110



SPECTRUM ON AGING

An International Conference on Gerontology

March 29-April 3, 1981
Sheraton Bal Harbour Hotel
Miami Beach

The Program

A multidisciplinary conference which will appeal to physicians, nurses, community support people, social workers, administrators, planning staff, trustees and volunteers. SPECTRUM ON AGING will feature many of the most well known and respected professionals in the field of Gerontology today.

Sponsored by

Mount Sinai Medical Center of Greater Miami
Miami Jewish Home and Hospital for the Aged
Florida International University
University of Miami School of Medicine
American Hospital Association

Continuing Education

31 CME credit hours 375 FNA contact hours

For information, mail coupon to:

Office of Planning/Mount Sinai Medical Center
4300 Alton Road/Miami Beach, Florida 33140
or call (305) 674-2408

JFMA

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

FROM DIETARY COMPLAINTS



"Too Bland"



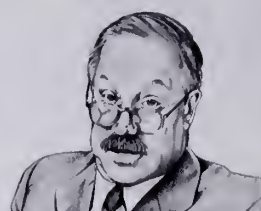
"Tasteless"



"No Variety"



"Hard To Cook"



"Only
Cottage Cheese?"



"Daddy's
Dull Diet"

TO COMPLIANCE

INTRODUCING *New Age*TM SANDWICH SLICES

- 90% less cholesterol
- 75% less saturated fat

Now, New Age—a cheese substitute made with vegetable oil—provides the good taste of process cheese without its restrictively high cholesterol content.

New Age has 90% less cholesterol, 75% less saturated fat, yet provides all the protein, vitamins and minerals of process cheese... good news for all health-conscious patients!

AMERICAN
SWISS
SMOKEY
HOT PEPPER



*New Age*TM

is consistent with
the cholesterol-control,
low-fat recommendations
of the third edition of
**The American
Heart Association
Cookbook.**



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

FEBRUARY 1981 • VOL 68 • NO. 2 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.
E. Charlton Prather, M.D.

Assistant Editors

James K. Conn, M.D.
Lee A. Fischer, M.D.
Edward Pedrero Jr., M.D.
J. Lee Dockery, M.D.
(from Board of Governors)

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Susan L. Milhoan

Consulting Editorial Staff

William A. Alonso, M.D.
Rud S. Ashkar, M.D.
Hubert A. Aronson, M.D.
Thomas D. Bartley, M.D.
Robert L. Batey, M.D.
Pierre J. Bouis Jr., M.D.
Ms. Deborah B. Wilbur
William T. Branch, M.D.
Miguel A. Brito, Jr.
Manuel L. Carbonell, M.D.
Donald W. Case, M.D.
Louis E. Cimino, M.D.
Charles Craig, M.D.
J. Jay Cummings Jr., M.D.
Paul deVelasco, M.D.
James E. Deming
Ablo Enriquez, M.D.
Richard A. Essman, M.D.
Franklin J. Evans, M.D.
Robert F. Feltman, M.D.
Richard Feinstein, M.D.
Lawrence M. Fishman, M.D.
John W. Glotfelty, M.D.
Allan L. Goldman, M.D.
Henry L. Harrell, M.D.
Allan Herskowitz, M.D.
James T. Howell, M.D.
Roy H. Hutchinson, M.D.
Rublin Klein, M.D.
Karl J. Kramer, M.D.
R. G. Lacsamana, M.D.
Richard F. Lockey, M.D.
Philander D. Morgan, M.D.
George Morris, M.D.
George A. Neder Jr., M.D.
Richard S. Panush, M.D.
R. A. Penalver, M.D.
John K. Petrakis, M.D.
Phillip B. Phillips, M.D.
Michael R. Redmond, M.D.
Albert L. Rhoton, M.D.
James F. Richards Jr., M.D.
Arvey I. Rogers, M.D.
Lees M. Schadel, M.D.
Guy T. Selander, M.D.
Roberto A. Sosa, M.D.
John Stone, M.D.
Edward J. Sullivan, M.D.
Robert H. Threlkel, M.D.
Benjamin E. Victorica, M.D.
Norman H. Wasserman, M.D.
Thomas M. Wiley, M.D.
Charles D. Williams, M.D.
Governor M. Witt, M.D.
Frederic C. Wurtzel, M.D.

Subscription Rate: \$15.00 per year, single copy, \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

Scientific Articles

- 99 Quinsy: Peritonsillar Abscess Revisited
*John H. Isaacs Jr., M.D.,
and Nicholas J. Cassisi, D.D.S., M.D.*
- 103 Community Mental Health Centers Pro and Con
Philip B. Phillips, M.D.
- 108 Acute Leukemia Mimicking Acute Appendicitis
Rony Ackerman, M.D., and Paulette Mehta, M.D.
- 110 Dermoid Cysts of the Floor of Mouth
J. Andrew Burnam, M.D.

Special Articles

- 113 Worker's Compensation Revisited 1980
James F. Richards Jr., M.D.

Editorial

- 85 How Much Is Enough?
James K. Conn, M.D.

Organization

- 94a Board of Governors Summary
123 Annual Meeting Scientific Program
Offers Something for Everyone

Departments

- 83 President's Page
Interaction with the Legislature
T. Byron Thames, M.D.
- 93 Professional Liability Legal Update
- 119 FMA Auxiliary
Auxiliary Respects Time
Mrs. Fred P. Swing
- 129 Medical News Around the State
- 131 Correspondence
- 135 Meetings
- 139 Classified Advertising
- 142 Index to Advertisers
- 142 FMA Officers and Council Chairmen

Cover

The photograph on the cover this month was taken from a Gemini satellite, August 14, 1965, and depicts Florida from the Keys north. The photograph is the property of NASA, and is used with permission. The Editor gratefully acknowledges the assistance of Joseph C. Von Thron, M.D., of Cocoa Beach in securing this photo.

SPECIFY
ZYLOPRIM[®]
(allopurinol)
THE
ORIGINAL
ALLOPURINOL



Two convenient dosage forms:
100 mg (white) and 300 mg (peach)
Scored Tablets



Tablets imprinted with brand name to
assist in tablet identification.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



President's Page

Interaction with the Legislature

We are fast approaching another session of the Florida Legislature. It is a time of promise and concern. Promise—in the hope that many of the things which are passed by the Legislature may be favorable to our profession and each of us individually. Concern—because in every session many bills are introduced which we find collectively and professionally and individually unpalatable.

The staff and our legislative counsel have identified many of the pre-filed bills which will affect our profession and are knowledgeable about others which are expected to surface during this term. We are prepared to offer expert testimony using our own FMA physicians in support of or opposition to bills. We are geared to keep you informed of important legislative events and, with the help of our Auxiliary, we are ready to enlist your support in the event an all out effort is required. You have always responded in an overwhelming way when requested.

Our greatest strength, however, is a membership informed about the issues and specific bills involved. We make special efforts to keep you informed during the Legislature by our Legislative Bulletin. You should read the summaries of legislative activities in your daily newspaper. Watch some of the session highlights on educational television. Discuss the issues with your colleagues. Discuss the issues with your legislators—face to face is best but letters or telegrams or phone calls are also effective.

Members of the Florida House and Senate know that their continued service in these bodies depends upon their being responsive to the needs and desires of

their constituents at home. They pay attention when the voters of their district express an opinion on an issue—especially if the voter has contributed money or effort to the campaign of the legislator.

We have effective legislative liaison through our Tallahassee Office, Legislative Council, and Council on Specialty Medicine. If you need help expressing your views on an issue or wish to find out what the FMA position is on a particular item of interest, our Tallahassee Office can assist you. Sometimes our members are the first ones to alert us to bills which their hometown legislators are going to introduce which will affect our programs. We encourage your active participation in the legislative process.

If you haven't seen the Florida Legislature in action firsthand, seriously consider signing up for the Doctor of the Day program. You will have an overnight room accommodation paid for by the FMA, sit with your local legislators in the House and be introduced on the floor of the House. You will become closer to your own elected representatives and you'll understand how the whole system works if you are there to experience it.

Sometimes we think the system is slow and cumbersome with hearings and testimony and endless debate and amendments and parliamentary procedures but still it produces the best system of government yet devised by man.

Become a part of the process this session by participating with your FMA leadership and staff in working for the best possible program for the people of Florida whom we all serve—legislators and physicians alike.

The P.I.P.E.R. report tells you how well your pension plan is being managed. Which is why you've probably never heard of it.

Only one equity fund manager in Florida is likely to call your attention to P.I.P.E.R.

Southeast Bank.

Because no other Florida bank, insurance company or trust company was evaluated as highly by this well-recognized rating service.

In analyzing the performance of 190 major banks and insurance companies all over the U.S., P.I.P.E.R. (Pension and Investment Performance Evaluation Report) rated Southeast in the top 20%. What's more, P.I.P.E.R.



noted that our rate of return was an outstanding 18.3% over the past two years.

Clearly, Southeast is not only the largest bank in Florida, we are also the best in the State in managing trust assets.

Call us for more information on the P.I.P.E.R. report and additional information on the kind of trust services we provide.



Southeast Bank
You can count on us.®

Member FDIC

Bradenton (813) 748-4262 • Deerfield Beach (305) 421-2200 • Fort Lauderdale (305) 561-7942 • Fort Pierce (305) 464-0050
Jacksonville (904) 358-7752 • Largo (813) 585-8558 • Miami (305) 577-3784 • Naples (813) 261-5225
New Smyrna Beach (904) 428-2401 • Orlando (305) 843-4000 • Riviera Beach (305) 848-7232 • Sarasota (813) 953-8137

How Much is Enough?

It has been puzzling to me to observe the inadequate funding of some programs authorized or even mandated by the Legislature, and at the same time see additional programs added on, aggravating the distress and frustration incurred in trying to deliver on promises.

An example is Medicaid. Although total dollars appropriated has increased progressively, the adequacy of funding for each program becomes less and less. In spite of this, the Legislature authorizes about three new programs each session. I had difficulty understanding this until I had my eyes opened during a conversation with a representative of HEW (now HHS).

Exhibiting my naivete, I expressed the opinion that programs should be cut back and restricted to accommodate the funding; that it would be better to do a little bit well than to try to do a whole lot poorly. That was a shocking and unacceptable concept. I was informed that funding was not the important thing — rather “Think how wonderful it is just to be able to offer all these programs.” In summary, the impression I was given was that the central theme was constant expansion, planning and offering being more important than providing.

A recent column by Richard Reeves, columnist for *The Tallahassee Democrat*, was thought provoking and also sobering — if not down right frightening. It was written in response to the defeat of Proposition 9 in California, and pointed out the terror that the thought of its message brought to the hearts of our public employees and the unanimous front they presented in bringing about its defeat. It also pointed out that this segment of society (employees paid with tax money) is nearly numerous enough to cause passage or rejection of any proposal which might be placed before the American people.

Imagine the potential therein for self-perpetuation. Of course, government mandated medical programs are only one small facet of the pervasive big government problem. However, it is the one facet we doctors should know something about and with which we should be con-

cerned. If we could restore some sanity to our segment, then perhaps other groups would follow our example in those segments which are their concern. Few of us will argue against the principle that all people should have good, appropriate medical care available to them when they need it. Also, most of us will agree that in this time there is a proper role of government to assure this.

However, there is divergence of opinion as to who should be helped by government and what medical services should be provided. Obviously, there is no way to provide all possible and desirable services for even a small segment of our population. However, this should not be so terrible, for almost everyone has to eliminate some possibilities, some desirables based on what he can afford.

To return us then to some degree of sanity regarding medical care, only two questions need to be answered: Who are the people who need government assistance to obtain medical care, and what medical care is truly necessary, essential and thus, a proper responsibility of government? I believe it is important for the medical profession to answer these questions for the country. A consensus must be found and once found, we must establish a position. Up to this point government aid is needed but beyond this point, government must not be permitted to pass.

Thomas Jefferson showed us the way when he defined the sum of good government as “a wise and frugal government which shall restrain men from injuring one another, which shall leave them otherwise free to regulate their own pursuits of industry and improvement, and shall not take from the mouth of labor bread it has earned.”

But Thomas Jefferson was speaking as a statesman and that has become an endangered species. In fact, it may be considered extinct for there have been no confirmed sightings in the last half of this century.

James K. Conn, M.D.
Assistant Editor
Tallahassee



UNIVERSITY OF MIAMI
SCHOOL OF MEDICINE

TUTORIAL COURSES OF
INSTRUCTION IN
CORONARY CARE

Director: Louis Lemberg, M.D.
Co-Directors: Agustin Castellanos, M.D.
Robert J. Myerburg, M.D.

SCHEDULE OF COURSES
1981

January	19-24	July	13-18
February	9-14	August	3-8
March	2-7	September	14-19
April	6-11	October	19-24
June	15-20	December	7-12

(For more information please call (305) 325-6411 or complete coupon and mail to: Y. Barcena, Cardiology (D-39), University of Miami School of Medicine, P. O. Box 016960, Miami, Florida 33101).

Please send me more information regarding
Tutorial Courses of Instruction in Coronary Care

Name _____

Phone () _____

Address _____

CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci.

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*).

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*.

Acute exacerbation of chronic bronchitis caused by *H. influenzae*.*

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacterium. Therapy may be instituted prior to results of sensitivity testing.

Contraindications: Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings: Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions: Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions: Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are onemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age. Patients with Renal Failure: Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

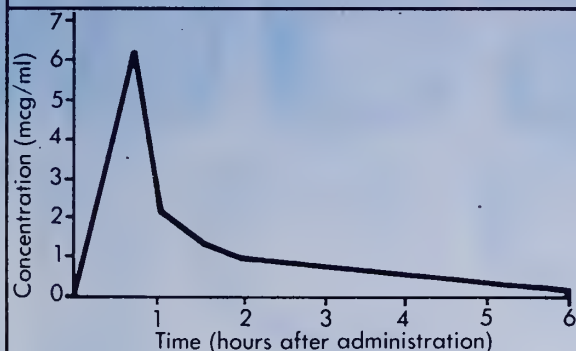
*Dosage should not result in a dose higher than that for adults.

†depending on severity

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on $T^{1/2}$ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Wyeth Laboratories • Philadelphia, Pa 19101



Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.[†]

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

[†]Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW
NAME



MEDICAL AND RELIGIOUS ASPECTS OF CIRCUMCISION
WEDNESDAY, MARCH 25, 1981
Wolfson Auditorium. Mount Sinai Medical Center



MORNING SCIENTIFIC SESSION:

8:30 AM — 12 NOON
\$10. registration fee includes:
Kosher Continental Breakfast
and Luncheon

AFTERNOON SESSION: 1:30 PM — 3:30 PM
OPEN TO GENERAL PUBLIC—NO REGISTRATION FEE

GUEST FACULTY

Rabbi Moses D. Tendler, Ph.D.
Professor of Talmud
Rabbi Isaac Elchanan Theological
Seminary of Yeshiva University
Chairman, Medical Ethics Committee
Federation of Jewish Philanthropies
New York City
Chairman, Bio Ethics Committee
Rabbinical Council of America

Rabbi Eugene J. Cohen, Ph.D.
Coordinator
Brith Milah Board of America

LOCAL FACULTY

Randy Makovsky, M.D.
Howard A. Engle, M.D.
Mount Sinai Medical Center

PROGRAM CHAIRMAN

Rabbi Solomon Schiff
Director of Chaplaincy,
Greater Miami Jewish Federation
Executive Vice President,
Rabbinical Association of Greater
Miami
Chaplain, Mount Sinai Medical Center

CO-CHAIRMAN

Irwin Makovsky, M.D.
Mount Sinai Medical Center

SPONSORED BY:

Greater Miami Jewish Federation
Jewish Federation of South Broward
Jewish Federation of Greater Ft. Lauderdale
Rabbinical Association of Greater Miami
Brith Milah Board of America

CO-SPONSORED BY:

Mount Sinai Medical Center of Greater Miami

For further information — Please call:

CME Coordinator: Mount Sinai Medical Center
Greater Miami Jewish Federation
Jewish Federation of South Broward
Jewish Federation of Greater Ft. Lauderdale

674-2311
576-4000, ext. 218
921-8810, ext. 25
484-8200

An apple a day won't keep alcoholism away!

The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

Do you have a patient who needs this kind of help? You probably do because the illness is sneaky. For more information and guidelines on how to identify these patients, write to us.

Willingway Hospital

311 JONES MILL ROAD
STATESBORO, GA. 30458

(912) 764-6236

J.C.A.H. ACCREDITED



Without the innovators, there could be no imitators

Librium® © (chlordiazepoxide HCl) Roche

Premarin (conjugated estrogens) Ayerst Laboratories

HydroDiuril (hydrochlorothiazide) Merck Sharp & Dohme

Lanoxin (digoxin) Burroughs Wellcome Co.

Lasix (furosemide) Hoechst-Roussel

Meticorten (prednisone) Schering Corporation

Anturane (sulfapyrazone) Ciba-Geigy Corporation

Erythrocin (erythromycin) Abbott Laboratories

Research and development, the life blood of pharmacotherapeutic progress

The drugs that have contributed so much to modern medicine were the product of long years of expensive research. And tomorrow's drugs depend upon continuation of the research and development going on right now. The cost of that research is one of the things reflected in the price of a brand-name drug. The substitution of a cheaper "generic" drug for a brand-name product may save the patient some money at the prescription counter. However, it threatens the very foundations of modern pharmaceutical research.

The hidden cost of "cheaper" generic drugs

Much of the enthusiasm for generic prescribing is based on a shortsighted view that fails to take such long-term issues into account. While cost is an important factor, pharmaceutical research, the quality of medicine, and future generations of patients must all be considered.

Settling for cheaper drugs today could deprive you and your patients of the drugs they may need tomorrow.



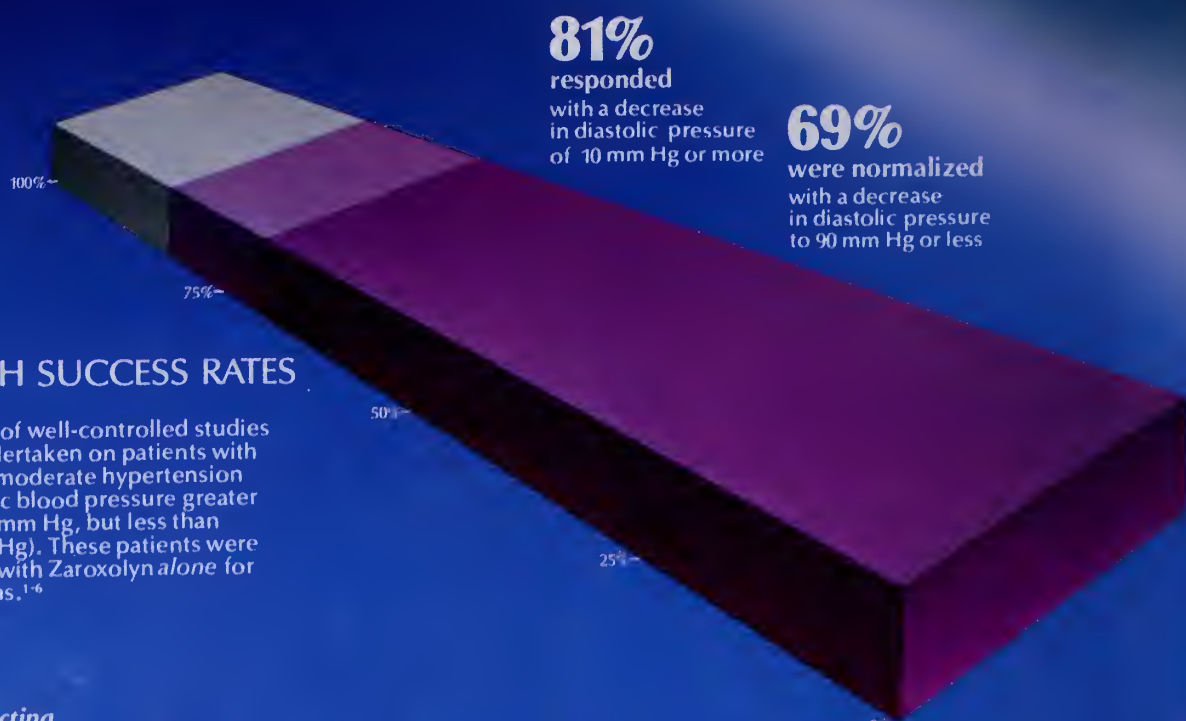
ROCHE

®

To encourage imitation is to discourage innovation

For Step-1 diuretic therapy that

start
with...



• HIGH SUCCESS RATES

A series of well-controlled studies was undertaken on patients with mild to moderate hypertension (diastolic blood pressure greater than 90 mm Hg, but less than 120 mm Hg). These patients were treated with Zaroxolyn alone for 6 months.¹⁻⁶

Long-acting
Zaroxolyn®... As much therapy as many of
(metolazone) Pennwalt

improves the bottom line...

stay
with

Long-acting
Zaroxolyn[®]
(metolazone) Pennwalt
2½ mg, 5 mg, 10 mg tablets

- NO TOLERANCE TO THE ANTIHYPERTENSIVE EFFECT NOTED IN LONG-TERM USE^{1,4,5}
- WELL-TOLERATED ANTIHYPERTENSIVE THERAPY¹... ONCE DAILY TO ENCOURAGE PATIENT COMPLIANCE

your hypertensive patients may ever need

Please see following page for prescribing information

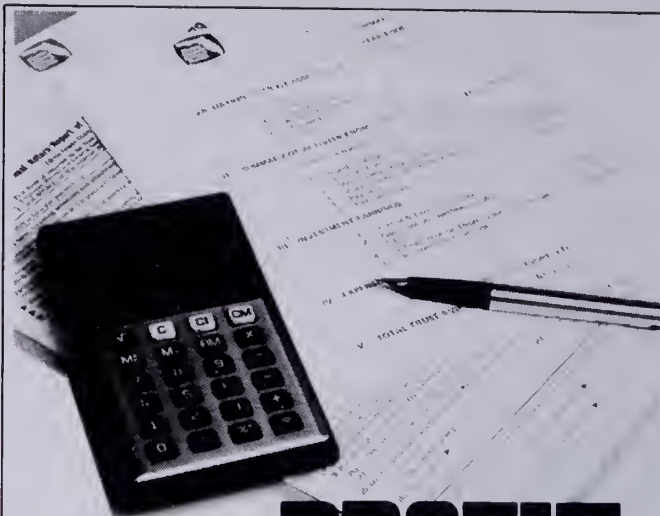
**Long-acting
Zaroxolyn[®]**
(metolazone) Pennwalt

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of child-bearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Van Hoose MC, Cutler RE: Antihypertensive efficacy of metolazone (Zaroxolyn[®]) alone and combined with reserpine in treatment of essential hypertension. *Curr Ther Res* 20:266-276, 1976. 3. Cangiano JL, Campos JA, Trevino A IV, et al: The effects of metolazone in the long-term treatment of essential hypertension. *Curr Ther Res* 16:778-785, 1974. 4. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Curr Ther Res* 20:745-750, 1976. 5. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18:527-533, 1975. 6. Materson BJ, Oster JR, Perez-Stable EC: Antihypertensive effects of metolazone (Zaroxolyn). *Curr Ther Res* 16:890-896, 1974.

R_x DIVISION
PENNWALT
ROCHESTER NEW YORK 14602

A-254



PROFIT FROM OUR EXPERIENCE

For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

We specialize in attaining the results that you require from your account in the areas of:

- **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.
- **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.
- **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

PEOPLE WHO KNOW HOW.

**Florida National
Trust Services**

214 Hogan Street
Jacksonville, Florida 32231
Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC



Professional Liability Legal Update

Regulation of Medical Staffs

There are numerous Florida statutes and regulations pertaining to physicians as members of hospital medical staffs. Because inquiries are often directed to us concerning these laws, we felt it might be helpful to set forth a brief outline of the requirements imposed by these statutory provisions and regulations.

Pursuant to Chapter 395, Florida Statutes, the Florida Department of Health and Rehabilitative Services (HRS) is charged with the responsibility of licensing hospitals and conducting annual inspections to determine if the hospital is entitled to retain its license. Section 395.065 provides that medical staffs are authorized to suspend or revoke staff privileges for good cause if the procedures for such action comply with the Joint Commission on Accreditation of Hospitals (JCAH) standards and the principles of participation in the federal health insurance program for the aged (i.e., Medicare). Section 395.0653 authorizes medical staff to review for approval or disapproval all staff applications and annual reappointments to the staff and to make recommendations on each to the governing authority.

Chapter 10d-28, Florida Administrative Code, contains the regulations adopted by HRS to control hospital licensure. The pertinent sections are as follows:

(A) Section 10d-28.52 defines medical staff as a formal organization of physicians with the delegated responsibility to maintain proper standards of medical care and continued betterment of that care.

(B) Section 10d-28.54 provides that the purpose of consultations and surveys conducted by HRS is to insure that the hospital is complying with the rules and standards established by HRS.

(C) Section 10d-28.56 sets out the responsibility of the governing body in rela-

tion to appointments to the medical staff. The governing body must have rules and bylaws which provide for appointment, reappointment, or dismissal of members of the medical staff, together with the procedure for hearing and appeal. Further, the regulations require that no action on appointment, reappointment, or dismissal may be taken without prior referral to the medical staff for their consideration and recommendation; and the governing body may only appoint members as recommended by the staff.

(D) Section 10d-28.58 sets out the requirements for the staff and makes the staff responsible for the quality of medical care provided by and for the ethical and professional practices of its members.

(E) Section 10d-28.58(d) provides that the staff has responsibility for recommending withdrawal of privileges, but only after an investigation with staff members having a right of hearing before the staff or a committee thereof.

(F) Section 10d-28.58(f) requires a committee of the staff to evaluate the quality of medical care for all categories of patients.

(G) Section 10d-28.58(g) requires that the staff review hospital admissions, length of stay, discharge practices, and evaluation of the services ordered for the patients of the hospital.

Section 395.501 *et. seq.* establishes a Hospital Cost Containment Board. This Board is located in the Department of Insurance. The Board conducts budget reviews of hospital costs as its principal function. Section 395.511 requires hospitals to maintain a quality assurance program to monitor the necessity of admissions, length of stay, proper utilization of services, and to evaluate the quality of services rendered.

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

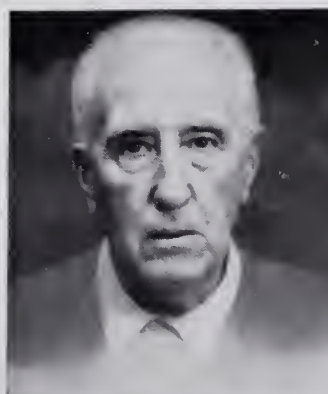
Chapter 458, Florida Statutes, the Medical Practice Act, creates the Board of Medical Examiners (BOME), which was reorganized in 1979 and placed under the supervision of the Department of Professional Regulation. The pertinent sections of this Act provide as follows:

(a) Section 458.301 and 458.309 authorize the BOME to adopt rules to protect the health, safety, and welfare of the public against the practice of medicine by unsafe and incompetent practitioners by insuring that "every physician practicing in the state meet minimum requirements for safe practice".

(b) Section 458.337 requires that the Department of Professional Regulation be notified

when any physician has been disciplined in any manner by a licensed hospital or medical staff, or that hospital, for any act that constitutes a violation of Chapter 458. Failure of any organization taking such action to report it to the Department within 30 days subjects the offending organization to a fine of up to \$1,000.

Section 768.40 authorizes hospital medical staffs to establish a Medical Review Committee for the purpose of evaluating and improving the quality of health care rendered were indicated and performed in compliance with the applicable standard of care. The statute also provides a qualified immunity for committee staff members from civil liability for any act undertaken or performed within the scope of the functions of the committee.



Dual-action therapy to enhance mental and physical activity in the elderly.

MENICTM

PENTYLENETETRAZOL 100 mg • NICOTINIC ACID 50 mg

Menic combines the proven effectiveness of cortical stimulation and cerebral vasodilation, reducing mental confusion, faulty memory and negative social behavior often associated with the senility syndrome.

DOSAGE: Two tablets after each meal.

SIDE EFFECTS: Occasionally flushing and pruritus associated with niacin administration.

PRECAUTIONS: Use with caution in patients with low convulsive threshold, focal brain lesions, severely impaired liver function,

peptic ulcer, diabetes, and gall bladder or liver diseases. Niacin may potentiate hypotensive drugs, phenothiazine derivatives and inactivate fibrinolysin.

CONTRAINDICATIONS: There are no known contraindications to Menic.



GERIATRIC PHARMACEUTICAL CORP. 397 JERICHO TURNPIKE, FLORAL PARK, N.Y. 11001
PIONEERS IN GERIATRIC RESEARCH . . . DEVELOPERS AND SUPPLIERS OF CEVI-BID • GAYSAL • ISO-BID

Fifty Years Ago

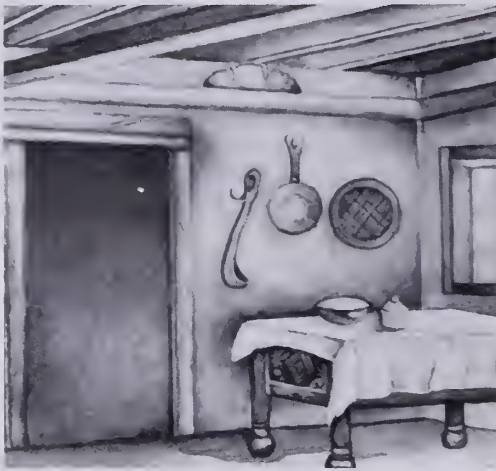
In *The Journal of the Florida Medical Association* for February 1931:

The annual pre-convention meeting of FMA officers, committeemen and councilors is scheduled for February 23 at the Windsor Hotel in Jacksonville . . . **Dr. John E. Boyd** was presented with an oil portrait of himself at the annual staff meeting of the Duval County Hospital in Jacksonville. The portrait was presented to recognize Dr. Boyd's many years of distinguished service . . . **Dr. Julius C. Davis** of Quincy recently visited Tallahassee, Lake City and Jacksonville in connection with his duties as President of the FMA . . . **Dr. T. Z. Cason** of Jacksonville recently attended a meeting of the Florida Health Council at Haines City . . . The home of **Dr. and Mrs. F. Clifton Moor** of Tallahassee was badly damaged by fire . . . Representatives of the Hillsborough County Medical Society attended the annual banquet of the Pasco-Hernando-Citrus County Medical Society on January 13 in Dade City. The fact that 30 people attended as seen as "an indication of the growing interest in this society." . . .

And so it was in Florida medicine 50 years ago this month. — EDH

Yesterday's Folk Remedy:

A rye loaf in the rafters.



Early in this century in Central Europe, almost every farm family kept a loaf of moldy rye bread on one of the kitchen beams. When any family member was cut or bruised, it was an old custom to cut a thin slice from the outside of the loaf, mix it into a paste with water, and apply it to the wound with a bandage. It was believed that no infection would then result from the cut.¹



Today's Tradition: **Tegopen**[®] (cloxacillin sodium)

for the treatment* of
known or suspected
staphylococcal
infections such as:

- Acute sinusitis
- Furunculosis and carbuncles
- Impetigo
- Secondarily infected dermatitis
- Cellulitis
- Abscesses
- Infected sebaceous cysts

In serious, deep-seated
staph infections, 500 mg
q.i.d. dosage is
recommended.[†]

- Tegopen has been reported active against 96% of *Staphylococcus aureus*.²
- 80% of *S aureus* has been reported resistant to amoxicillin and ampicillin.^{‡2}
- 88% of *S aureus* has been reported resistant to penicillins G and V.^{‡2}
- Staph resistance to erythromycin may develop during a course of therapy.³



Available as 500-mg and 250-mg capsules and Oral Solution 125 mg/5 ml.

Tegopen[®] (cloxacillin sodium) Today's Penicillin for Today's Physician

1. Florey HW, Chain E, Heatley NG, et al: *Antibiotics*. London, Oxford University Press, 1949, p 2.
2. Bac-Data Bacteriologic Report, Professional Market Research, 1978-1979. The clinical significance of *in vitro* data is unknown.
3. Erythromycin prescribing information (in *Physicians' Desk Reference*, ed 34. Oradell, NJ, Medical Economics Co, 1980) states that staph resistance may develop during treatment.

See brief summary of prescribing information on an adjoining page.

Copyright © 1981, Bristol Laboratories

*Note: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin.

†In serious, life-threatening infections, oral preparations of the penicillinase-resistant penicillins should not be relied on for initial therapy.

‡Not all isolates may have been tested using both discs.

Tegopen[®]

(cloxacillin sodium)
Capsules and Oral Solution

Brief Summary of Prescribing Information

For complete information, consult Official Package Circular
(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg q 6h.

Children: 50 mg /Kg /day in equally divided doses q 6h. Children weighing more than 20 Kg should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B. INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg in bottles of 100 500 mg in bottles of 100
Oral Solution—125 mg /5 ml in 100 ml and 200 ml bottles

BRISTOL[®]

Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201

The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment



**CONVENTION
PRESS, INC.**

2111 NORTH LIBERTY ST.

**JACKSONVILLE,
FLORIDA 32206**

PHONE 904/354-5555

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

FEBRUARY 1981
VOL 68 • NO. 2

Quinsy Peritonsillar Abscess Revisited

John H. Isaacs Jr., M.D., and Nicholas J. Cassisi, D.D.S., M.D.

Abstract: This paper reviews the differential diagnosis, incidence and pathology as well as possible complications of peritonsillar abscess.

Treatment consists of IV fluids and antibiotics and drainage of pus. A tonsillectomy is done immediately or six weeks later.

A University of Florida study is underway using a somewhat different approach. A tonsillectomy is not done on a routine basis. Nineteen patients were found to have confirmed evidence of peritonsillar abscess. None of these patients had a recurrence of peritonsillar abscess, though in one case a persistence of an inadequately drained abscess was noted.

Quinsy takes place when a copious and viscid defluxion from the head flows into the jugular veins, and . . . they attract a great defluxion and, owing to the defluxion being of a cold and viscid nature, it becomes infected obstructing the passages of the respiration and of the blood . . . Hence they are seized with convulsive suffocation, the tongue turning livid, . . . from a soft consistency it grows hard; instead of being flexible it becomes inflexible so that the patient would soon be suffocated unless speedily relieved.

Thus Hippocrates described peritonsillar abscess or quinsy. His treatment had some merit and some puzzling aspects. He suggested giving warm gargles and hot soaks to the neck as well as oral fluids. He further recommended opening the sublingual veins, shaving the head, and the juice of ptisan.¹

Since the Golden Age of Greece there has been significant progress in the treatment of quinsy, most notably in this century. Improved surgical and anesthetic techniques as well as the development of systemic antibiotics have improved the outlook in the treatment of this disease.

The diagnosis, differential diagnosis, incidence and pathophysiology, as well as possible complications, are discussed in this presentation. Finally, the approach we have developed at the University of Florida in an ongoing study, as well as some of our preliminary results in dealing with this problem, is presented.

Diagnosis

The typical patient with a peritonsillar abscess is a young individual usually in his 20s or 30s with a recent history of acute tonsillitis.² Quite often he has been treated by another physician but has had a progressive sore throat usually worse on one side. The patient often presents to the emergency room with complaints of severe pain, dysphagia, ipsilateral otalgia, increased salivation and trismus. In addition, there may have been a voice change.

The signs include fever of approximately 100 F which on occasion may be much higher. The patient may

The Authors

JOHN H. ISAACS JR., M.D.

Dr. Isaacs is with the Department of Surgery, University Hospital, Jacksonville, and is Assistant Professor at the University of Florida College of Medicine, Gainesville.

NICHOLAS J. CASSISI, D.D.S., M.D.

Dr. Cassisi is Professor and Chief of the Division of Otolaryngology, University of Florida College of Medicine.

speaking with a classical "hot potato voice" and may be drooling. There is pain on moving the head sideways and there will be enlarged nodes in the neck. Examination of the affected area is extremely difficult because of marked trismus. However, upon looking inside the patient's mouth the diagnosis will often be obvious.³ There is usually unilateral erythema and marked swelling; the palate and uvula are pushed toward the opposite side. Pus can often be aspirated from the area. Two presentations may confuse this clinical picture. The first is development of bilateral simultaneous disease, which is rare, and the other is infection behind the tonsil which may push the tonsil forward instead of to the side.⁴

Differential Diagnosis

Differential diagnosis commonly includes acute tonsillitis. Other somewhat more rare disease processes can mimic this disease. Tularemia has presented as peritonsillar abscess.⁵ There has been a report of a carotid aneurysm which expanded into the peritonsillar area which fortunately was not subjected to attempted drainage.⁶ It is also possible to have an abscess in the peritonsillar area despite the fact that the patient has had a previous tonsillectomy as we have seen in one of our clinic patients at Shands Teaching Hospital.

It should also be remembered that mononucleosis can be associated with peritonsillar abscess.

Incidence

The exact incidence of the disease is difficult to ascertain. In a large series of peritonsillar abscesses, Bonding reported that 11% of patients had a previous episode of quinsy.⁷ In another large series, 522 patients with acute streptococcal tonsillitis were treated with antibiotics and none developed peritonsillar abscess, however, in 391 not treated, seven abscesses developed for less than 2% incidence.⁸

Pathophysiology

The pathogenesis of peritonsillar abscess is straightforward. Tonsillitis develops and the tonsillar crypts become filled with epithelial debris and white cells. Since the large crypts in the supratonsillar fossa are in intimate relationship with the posterior and outer aspect of the tonsil, the infection extends through the capsule to form an abscess in surrounding tissue which is usually in the supratonsillar fossa.^{3, 4} An abscess may form in the tonsil itself but this is a relatively rare occurrence.

The abscess causes marked swelling and erythema of the soft palate pushing the tonsil medially and downward. The medial pterygoid becomes irritated causing trismus and swallowing becomes painful.

Bacteriological studies may show streptococcus pyogenes, staphylococcus aureus, Gram negative organisms or anaerobic organisms especially bacteroides.⁹ Culture may occasionally be unrewarding because of prior antibiotic treatment.³

Complications

Complications, although rare since the patient usually seeks help, may be disastrous. The natural course of the disease usually involves spontaneous rupture into the mouth. This can lead to various problems, depending upon the patient's state of consciousness and amount of debilitation. It is possible to aspirate the purulent discharge and/or blood with resultant serious pulmonary complications.

An even more serious course of events involves extension through the superior constrictor muscle into the neck with several ominous possibilities. The infection can involve and break down the carotid leading to massive hemorrhage. The infection can also extend into the mediastinum.

Local venous thrombosis and phlebitis can also occur. Endocarditis, nephritis, brain abscess and peritonitis have been reported. Rarely the infection can extend inferiorly causing supraglottic edema with obstruction requiring a tracheostomy. The infection can also extend into the thyroid cartilage and cause perichondritis.¹⁰

Treatment

At present there is difference of opinion as to optimal treatment although general agreement that intravenous fluids and antibiotics and drainage of pus are indicated.

A review of recent otological literature and textbooks show a divergence of opinion primarily concerning timing of the drainage. Some authors believe early treatment should consist of irrigation of the throat with warm solutions and analgesics and only if this fails should an incision and drainage be performed.¹⁰ Several textbooks state that early incision and drainage should be performed and followed by tonsillectomy six to eight weeks later.^{2, 3} At least one points out that often these patients never return, possibly because they are free of problems.

Recently there has been resurgence of a treatment described in 1859 by Chassaignac.¹¹ He recommended immediate tonsillectomy as the treatment for quinsy. In 1926, Baum described several problems with this treatment, the major one being pulmonary complications from aspiration of pus.¹² Apparently this argument was convincing enough to cause adaptation of the more conservative or classical approach described previously, i.e.,

antibiotics and incision and drainage to be followed by tonsillectomy several weeks later. The conservative approach was followed for several decades. Improved surgical and anesthetic techniques as well as systemic antibiotics seem to have allowed for the development of immediate tonsillectomy for quinsy without the previously described complications.^{13 14} The major advantages of immediate tonsillectomy are (1) one versus two hospitalizations, (2) minimal increased risks with maximal drainage and, (3) theoretically, the prevention of recurrent abscess.

At approximately the same time that there has been an increased interest in doing immediate tonsillectomy on this group, there has also been increased scrutiny in the medical community of the need for tonsillectomy in general.

The indications for tonsillectomy have come under close study. The efficacy of the procedure and the cost/benefit ratio have been challenged. However, the indications for tonsillectomy for peritonsillar abscess does not seem to have come under such close scrutiny. Upon reviewing the literature one finds a great deal of discussion on other aspects of the tonsillectomy problem but little directly concerning this particular problem. Sprinkle does mention peritonsillar abscess as a "complication" of tonsillar disease but does not address the problem as to whether this is an indication for removal.¹⁵ The State of the Art summarized the problems involved in determining the correct indications for tonsillectomy and, again, peritonsillar abscess is mentioned as a complication of tonsil disease. However, this article does not directly name previous abscesses as a direct indication for removal.¹⁶

A review of recent textbooks yields no definite answer either. Several authors recommend the "standard" treatment but cite no definite statistics to support their positions, others equivocate.

University of Florida Methods

At the University of Florida College of Medicine we have often followed a somewhat different approach from any of these standards. When the diagnosis is suspected, the patient is immediately started on intravenous hydration and antibiotics, usually penicillin G. An incision and drainage is performed in the clinic under local anesthesia and supplemental sedation. The patient is then treated intravenously for 12 to 72 hours with fluids, antibiotics and salt water irrigations. When stable and taking fluids well by mouth, the patient is discharged on antibiotics and continued irrigations and simply followed in our clinic. The routine follow-up tonsillectomy is not scheduled.

To investigate the effects of this treatment, records

were studied of all patients with peritonsillar abscesses admitted to the Shands Teaching Hospital from October 1976 to June 1979. If there was no definite evidence of a peritonsillar abscess, i.e., pus obtained by incision and drainage, the case was excluded. The patients were contacted either by telephone or by mail and seen in the clinic whenever possible in follow-up. (Follow-up clinic visits were somewhat difficult to obtain at times as this is a referral hospital with patients living a great distance away. Also, a large number of our patients come from the University student population which is a transient group.) The patients were questioned concerning subsequent tonsillectomy, recurrence of peritonsillar abscess, incidence of upper respiratory infections, sore throats, and requirements for antibiotics at later dates, as well as family income.

Results

Nineteen patients were found with confirmed evidence of peritonsillar abscess. We were able to contact 12 of them and obtain partial records on two others. (Table 1).

There were nine females and ten males. The age at time of abscess ranged from five to 39. Family income ranged from \$5,000 to over \$50,000 per year.

Only one patient had required treatments with antibiotics at a later date. There did not appear to be any increased incidence of sore throats, strep throats or

Table 1. — Patients with Evidence of Peritonsillar Abscess.

Patient	Sex & Age*	I & D	Tonsillectomy
# 1	M 22	04/20/79	05/ /79
# 2	F 18	02/16/77	07/01/77
# 3	F 27	12/08/78	02/05/79
# 4	F 23	02/17/78	04/10/78
# 5	M 21	05/26/78	09/11/78
# 6	F 35	08/01/77	NO
# 7	M 29	11/13/76	NO
# 8	M 19	11/03/76	NO
# 9	F 22	06/30/79	NO
#10	F 16	08/11/78	NO
#11	M 22	03/15/79	NO
#12	F 23	07/29/79	NO
#13	M 5	06/08/79	NO
#14	M 39	06/20/78	NO

*Age at time of I & D.

Table 2. — Indications for Tonsillectomy.

Patient	I & D	Tonsillectomy	Indications
#1	04/20/79	05/ /79	Persistent abscess
#2	02/16/77	07/01/79	Persistent sore throat
#3	12/08/78	02/05/79	Standard treatment
#4	02/17/78	04/10/78	Standard treatment
#5	05/26/78	09/11/78	Standard treatment

upper respiratory infections. Most patients noted one to two upper respiratory infections a year at most. In no patient on whom we were able to obtain follow-up was there a recurrence of a peritonsillar abscess, though one patient apparently had a persistence of an inadequately drained abscess which required tonsillectomy. Five of the 14 patients on whom data were available had a tonsillectomy at a later date. The indications for the tonsillectomies performed are presented in Table 2.

Discussion

There is no clear-cut answer to the optimal treatment of peritonsillar abscess. The classical approach is probably the safest, though some would consider it a major disadvantage that many patients never returned for their tonsillectomy.

Immediate tonsillectomy has much to recommend it especially in view of today's advances in anesthesia and with systemic antibiotics. It appears to be essentially as safe as a delayed tonsillectomy. It results in only one versus two hospitalizations and allows maximal drainage of the abscess. Possible disadvantages include the fact that it is possible to attempt this procedure under general anesthesia on a patient who does not have a peritonsillar abscess. Proponents of immediate tonsillectomy generally recommend that several hours be allowed to elapse before a tonsillectomy is performed. This most likely involves considerable discomfort on the patient's part whereas the relief with incision and drainage is obtained almost immediately.

We believe our approach combines the advantages

of both. It is the safest because it avoids an operation whenever possible and the possibility of aspiration while under general anesthesia is avoided. It also decreases the chance of operating on a simple, acute tonsillitis. Finally, it is probably the most cost effective for it avoids the expense of a trip to the operating room and only one hospitalization in the majority of patients. In the rare patient in whom peritonsillar abscess recurs, intermediate tonsillectomy would still have the advantage of decreased cost and allowing extensive drainage.

Summary

We have briefly reviewed the diagnosis and differential diagnosis, incidence, pathophysiology and complications of peritonsillar abscess. In addition we have discussed the various forms of treatment and have mentioned a form of treatment being used at the University of Florida College of Medicine. We have presented early preliminary results which tend to indicate that, while immediate tonsillectomy occasionally has a place in the treatment of peritonsillar abscess, it may be just as beneficial to simply treat with antibiotics, incision and drainage and follow up the patient on a PRN basis.

References

1. Adams, F.: *Genuine Works of Hippocrates*, translated from the Greek, 1939, pp. 81.
2. English, G.M.: *Otolaryngology: A Textbook*, New York, Harper and Row, 1976, pp. 435-436.
3. Adams, G.L., et al: *Boies' Fundamentals of Otolaryngology*, Philadelphia, W.B. Saunders, 1978, pp. 521-523.
4. Ballenger, J.J.: *Diseases of Nose, Throat and Ear*, Philadelphia, Lea and Febiger, 1977, pp. 263-265.
5. Everett, E.D. and Templer, J.W.: Oralpharyngeal Tularemia, *Arch. Otol.* 106:237-238 (Apr.), 1980.
6. Smith, T.E.: Case of Aneurysm of External Carotid Simulating Peritonsillar Abscess, *Trans. Amer. Laryng. Rhinol. Otolaryn. Soc.*, May 1928, pp. 401-404.
7. Bonding, P.: Tonsillectomy a chaud, *J. Laryng. Otol.* 87:1171-1182, 1973.
8. Chamovits, R., et al: Effect of Tonsillectomy on Incidence of Streptococcal Respiratory Disease and Its Complications, *Pediatrics* 26:355, 1960.
9. Sprinkle, P.M., et al: Abscesses of Head and Neck, *Laryngoscope* 84(7):1142-1148, 1974.
10. English, G.M.: *Otolaryngology*, Volume III, Chapter 46, Hagerstown, Harper and Row, pp. 19-20.
11. Chassaignac, E.: *Traite Pratique de la Suppuration et du Drainage*, Volume 2, Paris, Masson, 1959.
12. Baum, H.G.: Radical Cure of Peritonsillar Abscess, *Otol. Rhinol. Laryng.* 35:429, 1926.
13. Muller, S.P.: Peritonsillar Abscess: Prospective Study of Pathogens, Treatment and Morbidity, *Ear Nose Throat J.* 57:439 (Oct.), 1978.
14. McCurdy, J.A.: Peritonsillar Abscess, *Arch. Otolaryng.* 103:414 (July), 1977.
15. Sprinkle, P.M. and Veltri, R.W.: Tonsil and Adenoid Dilemma: Medical or Surgical Treatment? Symposium on Allergy in Otorhinolaryngology, *Oto. Clinics N. Amer.* 7(3):909, 1974.
16. State of the Art and Current Problems, *Ann. Otol. Rhinol. Laryngol.* 84:8-14, 1975.

- Dr. Isaacs, 655 West Eighth Street, Jacksonville 32209.

Community Mental Health Centers Pro and Con

Philip B. Phillips, M.D.

Abstract: Surveys show many Community Mental Health Centers have not achieved what Congress and the public expected. With decreasing psychiatric staffing, care of the indigent mentally ill becomes less important than service to people with ordinary problems in living. The number of psychologists, social workers and other mental health workers has greatly increased. State hospitals emphasize brief stays and rapid discharges thus increasing the numbers of patients with mental illness in communities. More psychiatrists must affiliate full or part-time in CMHC's or the chronically ill will receive inadequate care. Such a trend may turn CMHC's into simple social welfare organizations.

The CMHC of Escambia County is cited as a good free-standing center with adequate psychiatric staffing, excellent financial support and close affiliation with a state hospital. Continued emphasis on the mentally ill, adequate staff work loads, and meticulous cost accounting are obligatory if CMHC's are to survive effectively.

The Community Mental Health Centers of America are in trouble. Numerous studies and surveys have shown their deficiencies.^{1 2} Something must be done to improve the psychiatric care in these centers or psychiatrists must dissociate from them.

The act establishing these centers was signed in October 1963 and federal funding began.³ They were to be vehicles for treating mentally ill people in their own communities and were to provide early diagnosis, and continuous and comprehensive care. Some 700 centers have been assisted by federal funding, a number appreciably short of the 1,500 center objective but still enough to be accessible to 43% of the population. In the past few years criticisms have come from many sources and from many former supporters who have realized that centers have not lived up to their potential or promise.^{1 3 4}

Mistakes of the Past

A Committee of the American Medical Association chaired by Dr. Don Langsley, President-Elect of the American Psychiatric Association, reported in July 1979 that many centers did not seem to know whether they were part of a health system or social service system.

The Author

PHILIP B. PHILLIPS, M.D.

Dr. Phillips is a psychiatrist practicing in Pensacola.

Some tried to be all things to all people. The law requires 12 essential services but in practice services offered varied with the perceived needs of the community and the orientation and interest of the staff. It is, as this report points out, quite misleading for most centers to characterize all their services as "mental health" when few are psychiatric and most are social and educational in nature.³

Centers should be oriented to the medical model which requires a diagnosis and treatment program.^{3,5} Social services may be important adjuncts but should not be substitutes for treatment.

These centers were planned for and should still be directed toward treatment of mentally ill patients.² But, over 20% of the nearly 1 million persons who entered mental health centers in 1975 were diagnosed as "not mentally ill." From 1971 to 1975 a decreasing proportion of new cases were diagnosed as depressive disorders or schizophrenia. Increasing numbers of chronically ill patients left state hospitals for community care but in mental health centers the diagnosis of schizophrenia dropped from 16% to 10% and depressive disorders from 18% to 13%.³

Scarce dollars and manpower should not be directed to dealing with ordinary problems in living while letting demonstrable mental illness go untreated. The chimera of primary prevention has never been proved.^{3,6} Secondary prevention by identification and early treatment of mental illness is a much more important and rewarding activity. Centers should consider illness their primary responsibility but neither the quantity nor quality of avail-

able services is sufficient. Half the psychiatric patients are treated in the public sector and half in the private.⁷ Mental health centers are the places to which those people who cannot avail themselves of the private sector must turn.³ Yet, some centers emphasize serving the maladjusted rather than the mentally ill and some prefer the paying patient rather than the indigent because of budgetary needs.

There has been a shift in the proportion of professional staff personnel, illustrated by the fact that in 1972 centers averaged 60 full-time equivalent professional staff members. In 1976 this figure had increased to 76 full-time equivalent professional staff members. In 1970, centers averaged seven psychiatrists. Five years later the percentage of psychiatrists had dropped 33% while the psychologists had increased 70% and social workers 25%.⁷ Half the centers in 1976 had less than 2.3 full-time equivalent psychiatrists on the staff.^{3,8} This means that at the very time state hospitals are being emptied of patients with schizophrenia and affective disorders, the availability of people adequately trained to treat them in community mental health centers is decreasing.

In many centers psychiatrists are relegated to perfunctory roles.⁸ Often their primary role is to sign prescriptions and Medicare and Medicaid forms.⁹ One center in Tennessee hired a physician to come in at an hourly rate of pay and sign stacks of forms claiming payment for the center for patients whom he himself had never seen or treated. Little wonder that many psychiatrists are not satisfied with their positions or roles in the centers.³ Both psychiatrists and general physicians should be an important part of each center's staff because physical illness is present in an estimated 40% of patients. It follows, therefore, that psychiatrists should be responsible for the clinical direction of the center itself, a stand endorsed by the American Psychiatric Association.³ However, from 1973 to 1977 the percentage of psychiatrists employed as administrative directors dropped from 56% to 22%.^{3,5}

The leadership of the Assembly of District Branches of the American Psychiatric Association felt so much concern over deterioration of community mental health centers that a task force was appointed in 1976 which polled members of the Association throughout the country for opinions and suggestions on how centers might be improved. Almost 200 replies were received. They emphasized the lack of cooperation with District branches, arbitrary independence of the free-standing centers, reduction in status of the psychiatrist, extensive utilization of paraprofessionals, and the competitive, rather than a complementary and supplementary, relationship with the private sector of psychiatry. Some major deficiencies cited in the centers were lack of mature judgment by administrators, emphasis on financial expediency, failure to place mentally ill patients under treatment by

psychiatrists, triage by the least qualified personnel (often clerks or paraprofessionals) and the tendency to utilize psychiatrists in a consultative rather than a treatment role. The task force, after analysis of responses, made recommendations for improved patient care, for constructive relationships between centers and the private sector, and for better administration of the centers.¹

The Association's reference committee, in something less than an action-oriented decision, referred the Assembly Task Force to a not then organized task force on community mental health programs within the Council on Mental Health Services.¹⁰ This new task force, after reviewing the Assembly Task Force's report, gave strong endorsement to it and urged meetings with government representatives to discuss the concerns expressed in the report and stressed that Congress and the Executive branch of government should be focusing on the issues of accountability, psychiatric manpower, and the mandate that centers focus on the medical needs of those seeking care.⁹

One member of the Assembly Task Force had the temerity to propose that a two-channel system should exist in each mental health center so that "patients" with mental illness would be treated by qualified psychiatrists and "clients" with social adjustment problems would be in the "social channel," to be seen by nonmedical counselors. The merit of such a system seems clear today although there were members of the assembly who dared not be so frank.

The Chief of Psychiatry at a midwestern mental health center has recently proposed operational standards for medical practice in community mental health centers which delineate "clients" and "patients" and the proper handling of each category.¹¹ This is strong support for the plan previously described which appeared in the preliminary Assembly Task Force report three years earlier.

With so much conflict, confusion, and disaffection in the community mental health center program, why should psychiatrists concern themselves at all?^{3,12} For several reasons. The gradual takeover by psychologists and social workers and various paraprofessionals has come about because the Congress appropriated money for various categories of social problems and many psychiatrists did not have specific interest in these burgeoning programs. Huge grants for drug abuse, alcoholism, child development centers and senior citizens programs gradually overwhelmed the small psychiatric staffs attempting to treat the indigent mentally ill for whom psychiatrists thought the mental health center movement was originally planned. Disillusioned at their waning role and influence, many psychiatrists turned elsewhere for their professional careers.⁵

With the exodus of highly trained psychiatrists the

quality of professional care provided by the centers has gone down. The relative cost of psychiatric manpower was probably another factor in the minds of budget-conscious administrators who found they could get "two lieutenants for the price of one colonel."⁸ But they got into a situation where four such lieutenants could not replace the one colonel.

If national health insurance ever arrives upon the scene and if community mental health centers are designated as the primary source of treatment of mental illness we will, unless important staffing changes are made, have the majority of psychiatric patients receiving less adequate care than the more affluent people who can have private care. This would be a sad development since psychiatrists are the primary advocates for the mentally ill and have through the years devoted more concern to their treatment than all the various social agencies and legal groups now so vocally prominent. To preclude such an undesirable situation psychiatrists from the private sector must participate in the mental health centers, if only by part-time service. Leadership in raising the quality of care, willingness to take over the direction of those centers which are foundering, and a drive to get psychiatric residents back into the centers for experience in community psychiatry are needed.⁸ Or, physicians must get completely out of the mental health center program and develop an alternative and improved method of handling the indigent mentally ill.¹³

Escambia County Center

Not all centers are inadequately staffed.¹⁴ I have served as part-time consulting psychiatrist for the past 13 years in one center and served its predecessor for ten years. Beginning in 1954 a Child Guidance Clinic was initiated and in 1959 adults were added to the patient population and the name was changed to the Guidance Clinic. This served as the nucleus for the current Escambia County Mental Health Center which began in 1966. Local fund drives raised matching funds for federal grants and a local hospital donated a city block of land for new buildings. Expansion in staff, space and budget has continued. To five part-time psychiatrists a full-time psychiatrist was added in 1970 and a second in 1972. Currently four veteran part-time men each work eight hours a month in the Adolescent and Adult Program, primarily an outpatient after-care program for former hospital patients. The two full-time men care for an average of 20 inpatients in a contract-related general hospital. One senior psychiatrist long associated with the Center shares the indigent patient load with the two full-time men and for this is compensated individually through state funds provided to the Center under the Florida Mental Health Act, a 1972 legislative development called

the "Baker Act" which was designed to provide psychiatric patients limited inpatient care near their homes. His inpatient indigent load averages from six to 12 patients who are seen daily and later followed as outpatients in the after-care unit of the Center. The point is that necessary and appropriate inpatient and outpatient care is being provided needy psychiatric patients.

This Center functions under a Board of Directors now consisting of 39 local citizens many of whom have served for years.^{2,14} The Center and its Board are under the general supervision of the District Mental Health Board which distributes state funds to worthwhile programs in the five-county area in west Florida.

The District Board is made up of 15 to 20 representative citizens willing to serve. It is one of 15 boards in Florida under the State Department of Health and Rehabilitative Services.

During 1977-1978 this Center provided direct services to more than 11,000 Escambia County residents, a total of 1,600 persons more than served the previous year. Twenty thousand hours of consultation and educational services were provided to community organizations. Psychiatric topics covered in the educational program included depression, behavioral aspects of hypertension, weight control, stress, alternatives to drug usage, and effective parenting. The "Help Line" received over 12,000 calls during the 12-month period.

The Adult and Adolescent Program provided direct services to over 6,900 people during 1978, an increase of 2,400 over the previous year. The Alcohol Counseling Program served 2,300, a slight decrease from the previous year.

The Treatment Alternatives to Street Crime (TASC) screened 1,180 individuals in the county jail and 285 were referred for treatment as an alternative to incarceration.

This program is funded through the Law Enforcement Assistance Administration through contract with the county commissioners. The Child Development Center provided direct services to 1,500 compared to 2,100 the previous year and the Drug Counseling Program dealt with 1,214.

The growth of this organization is a reflection of "grantmanship" at its finest. It is said the director has the "key to the safe." He is frankly a master in obtaining federal and state funds. Local funds come from the county commissioners, city council, school board, United Fund and others. Each local dollar brings \$7 in federal funds and \$3 in state funds. A \$3 million expansion of space was assured by a recently obtained loan from the Farmers Home Administration. This will replace small leased buildings on which leases soon expire. Is this a forerunner of what other community mental health centers will be in the 80s?

With the current budget tightening that cities and

counties are facing, and a probable severe reduction in local funding with the attendant reduction in federal and state matching funds, there is an increasing emphasis on fees. Currently Medicare and Medicaid charges are filed for all services provided eligible beneficiaries and the administrative staff is constantly on the lookout for additional sources of revenue.

What the Future Holds

What then are some of the major conflicts and what does the future hold?

The majority of the staff work primarily with persons having what euphemistically might be called "problems in living." Little is ever said about mental illness. The two full-time, well-trained psychiatrists are at the third level in the organizational structure "supervised" by a psychologist who heads the Adult and Adolescent Program. All divisions or programs are headed by psychologists as is the Mental Health Center itself.⁸

Centers advertise for "clients," using radio and newspapers. They have sliding fee scales and in some instances the center's fees are higher than those of psychiatrists in the private sector.¹ Too few psychiatrists are on the staff in many centers and thus other disciplines see people who really should be "patients."⁸ In some centers scarce funds designated for health care are being diverted to provide counseling for "clients" with simple problems in living.³ In the Escambia County center two full-time psychiatrists and 0.45 part-time, full-time equivalent psychiatrists and a 0.15 part-time, full-time equivalent family physician are a very small but tremendously important part of a 250 person staff.

The Community Mental Health Center system begs for two channels of care, a medical channel for patients and a sociopsychological channel for "clients" with adjustment problems.^{1,11} Too few psychiatrists serve as executives or medical directors. Cost effectiveness should be a major factor in determining how centers should be operated. Waste should not be tolerated either through unnecessary employees, very light workloads or unnecessary programs. In the Escambia County center the adult and adolescent program treats 62% of the patients annually but receives only 37% of the budget.

Either national leaders in the Executive and Legislative branches of government become aware of the anti-medical bias of many center directors and take steps to restore centers to their original purpose or the program gradually becomes simply another expensive social agency for the unhappy, the misfits, the inadequates, and the personality disorders. If this trend continues the psychiatrists may need to develop in the private sector a system of quality care for mentally ill patients under government programs such as Medicaid, Medicare, or National Health Insurance. Such a system of private care

works quite well with contract psychiatrists treating Veterans Administration patients.

Or, if psychiatrists as a group reach the point of complete frustration with National Health Planners, who listen poorly at times to the experienced persons in the field, then psychiatry may drop out of the community mental health center program and default to the anti-medical disciplines. This would be ill-advised, inconsiderate of patients' needs and regressive to the specialty of psychiatry.

Conclusion

Described here is one of the older, larger, and better funded mental health centers. Good psychiatric care is provided and the staff has a close working relationship with the state hospital 160 miles to the east. State hospital admissions have been significantly reduced. There is good cooperation with the Vocational Rehabilitation program and adequate support from the District Mental Health Board. Yet in spite of a decrease of an average of ten staff persons per year in each of the past three years, the staff at times seems excessive, the individual work loads light, the cost per patient high, and the results often inconclusive.

Who speaks for the mentally ill in America if not the psychiatrists?¹² With a refocusing on goals and missions and renewed involvement on the part of American psychiatrists,⁴ community mental health center programs can survive but at an appreciable cost to the tax payers.⁸ Borus said it well in referring to the future of the Mental Health Centers.² He indicated if National Health Insurance provides free choice to patients through a fee for service voucher system, then the mentally ill could elect either community mental health center or the private sector and this would determine the success or failure of a center in the open market. Without a change from the present direction and without a renewed involvement by the psychiatrists, the center program may become simply another useful massive consumer of tax dollars out to save society from its social ills under the direction of empire-building persons seemingly allergic to the realities of frank mental illness.

References

1. Report of Assembly Task Force on Community Mental Health Centers, Oct. 30, 1977.
2. Borus, J.F.: Issues Critical to Survival of Community Mental Health, *Am. J. Psychiat.* 135:9 (Sept.) 1978.
3. AMA Report on Community Mental Health Centers, July 25, 1970.
4. Community Mental Health Centers Losing Favor, *AMA News*.
5. Report of Task Force on Community Mental Health Programs, March 1979.
6. Lamb, H.R. and Zusman, J.: Primary Prevention Perspective, *Am. J. Psychiat.* 136:1 (Jan.) 1979.
7. U.S. Psychiatrists Expected to Increase Their Institutional Ties, *Clin. Psychiat. News*, Vol. 7, No. 8, August 1979.
8. Winslow, W.W.: Changing Role of Psychiatrists in Community Mental Health Centers, *Am. J. Psychiat.* 136:1 (Jan.) 1979.
9. Report and Recommendations of Task Force on Community Mental Health Programs, Sept. 7, 1978.

10. Report of Assembly Task Force on Mental Health Centers, May 5, 1978.
11. Jepson, W.W.: Operational Standards for Medical Practice in CMHCs, (Aug.) 1979.
12. Hearings Begin on Carter Mental Health Proposal, Psychiat. News Vol. 14, No. 13, July 6, 1979.
13. Phillips, P.B. and Fischer, R.B.: Community Mental Health Centers or Is There a Better Way, J. Florida M. A., 1976.

14. Center Letter, Annual Report 1978, Community Mental Health Centers, Oct. 30, 1977.

- Dr. Phillips, 1515 West Moreno Street, Pensacola 32501.

AMA Clinical Update Meeting Set For Sarasota in Fall of '81

The AMA Council on Continuing Physician Education has identified Sarasota, Fla., as the site for a Clinical Update meeting, October 30 to November 1, 1981.

The meeting will be held at the Sarasota Hyatt House in cooperation with the Florida Medical Association, University of South Florida College of Medicine, and the American Academy of Dermatology.

Four and five-hour courses will be offered in several areas, including: basic life support-cardiopulmonary resuscitation; use of antibiotics; electrocardiography; dermatology for the non-dermatologist; practice management; rheumatology; management of diabetes melli-

tus; gastrointestinal disorders; pulmonary function and blood gases; neurology for non-neurologists; management of hypertension; and others.

The program has been certified for AMA Category I Credit on an hour-for-hour basis.

Course fees range from \$40 to \$60 each for AMA members and \$60 to \$85 for nonmembers.

Additional information may be obtained by contacting Mr. Gale K. Jewett, Assistant Director, Division of Continuing Medical Studies, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Acute Leukemia Mimicking Acute Appendicitis

Rony Ackerman, M.D., and Paulette Mehta, M.D.

Abstract: Leukemia, a common malignant disease in children, has varied clinical findings which may include such nonspecific complaints as poor appetite, lethargy, pallor, and bleeding. Rarely encountered are glaucoma, liver failure and paraplegia. Abdominal pain is not uncommon during the course of the disease but it is unusual as a presenting sign. Our patient, a 17-year-old girl, came to the emergency room with symptoms of acute appendicitis but study revealed acute lymphoblastic leukemia. The case emphasizes the importance of early diagnosis and the difficulty that may be encountered because of the malignancy's diverse presentations.

Leukemia is a common malignant disease of childhood and early detection and treatment are essential to prevent life-threatening complications. Usually acute leukemia in children presents nonspecifically with complaints of poor appetite and lethargy, and signs of pallor, bleeding, fever, and pain. Glaucoma, liver failure, and paraplegia have been reported.¹⁻³

We cared for a teen-age girl who had signs indicating acute appendicitis but instead was found to have acute lymphoblastic leukemia. The diverse nature of the presentation of acute leukemia is emphasized by this case.

Case Report

A 17-year-old white girl was seen in the emergency room one hour after acute onset of pain in the right lower quadrant radiating to the left lower quadrant. There was no associated fever, vomiting, or dysuria. During the previous month she had been seen for mild anemia and was treated with vitamins.

At physical examination the patient appeared to be well-developed and well-nourished but with acute abdominal pain. The temperature was 37°C, respiratory rate 24/min, heart rate 100/min, and blood pressure 100/60 mm Hg. The ears, nose and throat were normal. The chest was clear to percussion and auscultation. Abdominal examination revealed diffuse and point tenderness, rebound tenderness in the right lower quadrant, guarding and hypoactive bowel sounds. The liver and spleen were palpated. Small shoddy lymphadenopathy was present in the cervical region. Rectal examination showed no abnormalities. Evaluation of the extremities and central nervous system was negative.

The Authors

RONY ACKERMAN, M.D.

Dr. Ackerman is a pediatrician now practicing in Homestead.

PAULETTE MEHTA, M.D.

Dr. Mehta is Acting Chief, Division of Pediatric Hematology/Oncology, University of Florida College of Medicine, Gainesville.

Complete blood count showed hematocrit 27%, white blood cell count 3200/mm³ with 21% polymorphonuclear cells, 7% bands, 70% lymphocytes, and 2% monocytes. Platelets were estimated as decreased. Uric acid was 7.0 mg/dl, SGOT 265 IU/l, alkaline phosphatase 549 IU/l, and LDH 3630 IU/l. Stools were positive for occult blood. Urinalysis showed pH 7.0 with occasional red blood cells. Chest x-ray was within normal limits.

The diagnosis of acute appendicitis was considered. Barium enema and upper gastrointestinal series showed displacement of the bowel secondary to enlarged liver and spleen.

The patient was transferred to the University of Florida Medical Center for evaluation of the abdominal pain in the presence of hepatosplenomegaly. She appeared in acute distress secondary to pain. Vital signs were unchanged.

Review of the complete blood count revealed that the hematocrit was 22%, white blood cell count 3000/mm³ with several blast cells. Platelet by chamber count was 20,000/mm³ and bone marrow aspiration revealed hypercellularity with 90% replacement by lymphoblasts. Diagnosis of acute lymphoblastic leukemia was made and appropriate therapy begun.

Discussion

Acute abdominal pain alone is uncommon as the initial manifestation of acute leukemia. Iversen found that although approximately 20% of new patients with acute lymphoblastic leukemia had abdominal pain, only 3% had that single complaint leading to diagnosis of leukemia.⁴

In contrast, acute abdominal pain is a well known complication of acute leukemia during remission or relapse. Pain usually begins after initiation of treatment and may be due to cecal, appendiceal, liver and renal abscesses, rupture of abscesses into the peritoneum, pancreatitis, cholelithiasis, ruptured colon, intussusception and obstruction.⁵⁻¹⁰ Most patients with abdominal pain have been found to have typhilitis, appendicitis or "leukemic ileocecal syndrome."^{5,6} These complications probably are related to rapid involution of leukemic infil-

trates in the bowel wall secondary to chemotherapy with subsequent loss of vascular supply, inflammation, perforation, obstruction and/or hemorrhage. Fungal overgrowth and ulcers are often accompanying conditions.^{6 7} In one report perforation of the ileum followed by spontaneous closure was responsible for pain.¹⁰ However, leukemic infiltration per se is rarely a probable causative factor in the development of appendicitis.⁹

The cause of abdominal pain in our patient is not clear. It is unlikely that leukemic infiltrates per se caused such localized inflammatory changes. More likely hemorrhage and ulcerations developed in the appendiceal area secondary to severe thrombocytopenia. Positive stool guaiac examinations support this hypothesis.

This case demonstrates the importance of early diagnosis of malignancy which may be accompanied by abdominal pain. The finding may alter priorities for intensive surgical intervention and medical treatment. Surgical intervention may be reconsidered, however, and should be performed if indicated. It may be life-saving.⁹

The diagnosis of leukemia may be difficult because of diverse presentations. The disease should be suspected in patients with acute abdominal pain, especially when

associated with organomegaly and/or abnormal blood parameters, before surgical approach to treatment is accomplished.

References

1. Mehta, P.: Ophthalmologic Manifestations of Leukemia, *J. Pediat.* 95:156-157, 1979.
2. McCord, R.G.; Gilbert, E.F., and Joo, P.J.: Acute Leukemia Presenting as Jaundice with Acute Liver Failure, *Clin. Pediat.* 12:17A, 1973.
3. Stefansson, T. A., and Rask, B.E.: Acute Paraplegia as Initial Symptom of Acute Leukemia, *J. Neurosurg.* 39:648-651, 1973.
4. Iversen, T.: Leukaemia in Infancy and Childhood, *Acta Paediat. Scand.* (Suppl) 167:25-100, 1966.
5. Exelby, P.R.; Ghandchi, A.; Lansigan, N., and Schwartz, I.: Management of Acute Abdomen in Children with Leukemia, *Cancer* 35:826-829, 1975.
6. Sherman, N.J., and Woolley, M.M.: Ileocecal Syndrome in Actue Childhood Leukemia, *Arch. Surg.* 107:39-42, 1973.
7. Klener, P.; Donner, L.; Bocanova, M., and Ort, J.: Gastrointestinal Lesions and Complications in Haemoblastosis, *Folia Haematol.* 100:57-66, 1973.
8. Wagner, M.L.; Rosenberg, H.S.; Fernbach, D.J., and Singleton, E.B.: Typhilitis: Complication of Leukemia in Childhood, *Am. J. Roentgenol. Radium Ther. Nucl. Med.* 109:341-350, 1970.
9. Versteeg, K.; LaSalle, A., and Rather, I.: Appendicitis in Acute Leukemia, *Arch. Surg.* 144: 632-633, 1979.
10. Moore, T. C.; Finkelstein, J.Z.; Lachman, R., and Hirose, F.: Spontaneous Perforation and Closure of Small Intestine in Association with Childhood Leukemia, *J. Pediat. Surg.* 10: 955-977, 1975.

- Dr. Mehta, Pediatric Hematology-Oncology, University of Florida College of Medicine, JHM Health Center, Box J-296, Gainesville 32610.

Dermoid Cysts of the Floor of Mouth

J. Andrew Burnam, M.D.

Abstract: Dermoid cysts of the floor of the mouth are rare, comprising about 1.6% of all dermoid cysts. They result from epithelial rests trapped during midline closure of the first and second branchial arches.

These cysts may be either sublingual, geniohyoid or lateral and their presentation dictates the appropriate surgical approach. Cure is total; extirpation must be carefully done. Tracheostomy is rarely necessary.

For the lateral cyst, the approach is the standard one for the submaxillary gland which must be removed first, followed by the cyst which lies between the gland and the oral mucosa.

Although occurrence is relatively rare, intraoral dermoid cysts have been recognized for many years beginning with Jourdain in 1778.¹ In 1885 Butlin reported a case and its differential diagnosis.² Colp presented a small series in 1925 and in 1937 New and Erich reported 1,495 cases from Mayo Clinic, the all-time classic series.^{3,4}

Distribution of these cysts is of interest. New and Erich noted that only 6.94% occurred in the head and neck. Of their 103 cases only 24 or 23.4% involved the floor of the mouth. Of the total series by far the largest number were pilonidal cysts (42.48%) or ovarian cysts (42.13%). Among the head and neck cases most cysts occurred in the orbital area. All but five were noticed before the patients reached age 30, the majority being observed in the first five years.

Report of Case

A 75-year-old white woman was first examined on November 28, 1978. She had noticed swelling under her tongue some two to three years previously and the mass had been incised and drained on two occasions. The surgeon noted hair in the contents. The cyst promptly recurred and the patient again was bothered by changes in speech and difficulty with deglutition and mastication. She was concerned about the eminent possibility of problems with respiration. On December 13 the cyst was totally removed via a submental approach and with nasotracheal anesthesia. It proved to be a type II dermoid cyst of the geniohyoid type measuring 9 x 6 cm. The postoperative course was uneventful. The patient is considered cured (Figs. 1-6).

The Author

J. ANDREW BURNAM, M.D.

Dr. Burnam is Clinical Assistant Professor of Otolaryngology at the University of Miami School of Medicine, Miami.

This paper was presented at the 13th Annual Duke-McPherson Otolaryngology Symposium, Durham, N.C., May 18-20, 1979.

Discussion

Embryology

In 1978 Mikulecz stated that dermoid cysts of the floor of the mouth occurred in three ways: through midline closure of body cavities, closure of channels of clefts which, during fetal life, were covered with epithelium, and through abnormal deposits of epidermis in deeper tissues.³ These factors were reiterated by New and Erich who classified the abnormalities as (1) congenital dermoid cysts of teratoma type, (2) acquired implantation dermoid cysts, and (3) congenital inclusion dermoid cysts.

Almost all dermoid cysts of the head and neck fall into the latter variety. They are simple, thin-walled, lined by squamous epithelium and filled with a caseous, greasy material and occasionally contain hair. The teratoma types, in contrast, are thick-walled and squamous-lined but contain elements of all three germinal layers; thus, they may contain hair, bone, cartilage, teeth, brain, and glandular structures.

Meyer further suggested this classification of cysts of the floor of the mouth:⁵

Epidermoid — a simple cyst with an epithelial-lined wall.

Dermoid — a similar epithelial-lined cyst but which also contains skin appendages such as sebaceous and sweat glands, and hair follicles.

Teratoma — an epithelial-lined cyst but one which contains mesodermal and endodermal derivatives, i.e., bone, muscle, intestinal mucosa, etc., as well as dermal appendages.

Classification

Dermoid cysts of the floor of the mouth have been classified into three categories: sublingual or genioglos-



Fig. 1. — Preoperative. Note submental expansion.



Fig. 2. — Extensive intraoral displacement.



Fig. 3. — Kidney-shaped cyst measured 9 x 6 cm.

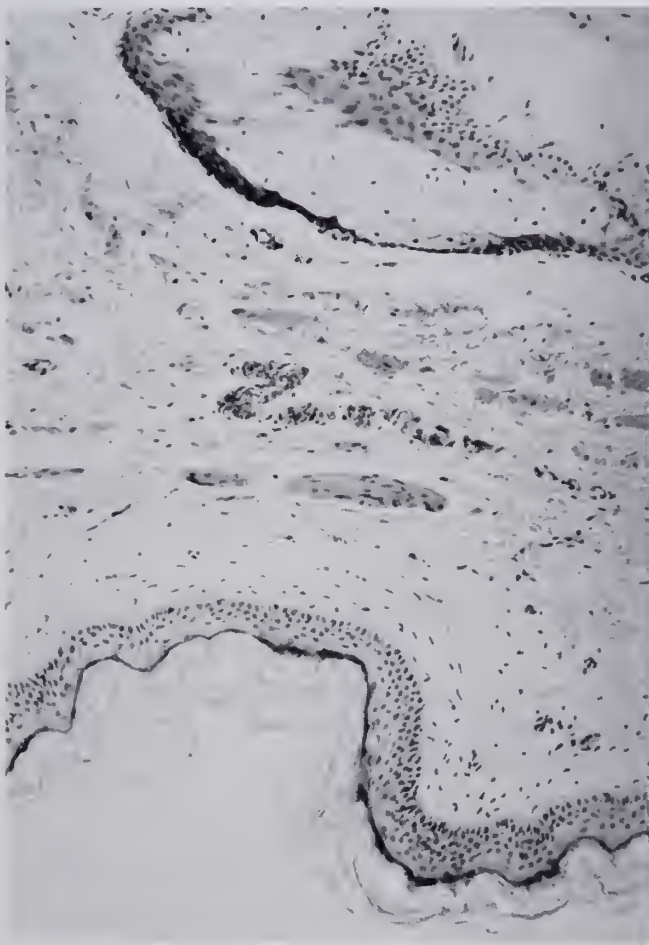


Fig. 4. — Squamous-lined cyst in which the wall contains sebaceous gland.

sal, geniohyoid, and lateral.⁶ Sublingual lie between the oral mucosa and the geniohyoid muscle and present intraorally. Geniohyoid lie between the geniohyoid and mylohyoid muscles and present as submental as well as an intraoral mass. Both are midline. The lateral cyst is located under the mandible in the submaxillary triangle and pushes the tongue to the opposite side.

Dermoid cysts present as painless, progressively enlarging swellings. If pain is present, it is due to secondary infection. Most cysts are found in young adults before age 30; however, there are exceptions. They should be distinguished from other swellings of the floor of the mouth such as ranula, blockage of Wharton's duct, infection, thyroglossal duct cyst and tumors, and inflammation of the sublingual or submaxillary gland.

Treatment

The treatment is surgical and the approach is determined by location. Those which present only intraorally should be approached via the intraoral route. Those with an extensive submental location are more safely and easily removed through a cervical approach. In either method, care must be taken to avoid injury to certain structures; namely, Wharton's duct and the hypoglossal and lingual nerves. Most dissection is performed bluntly with sharp dissection kept close to the cystic walls. Wharton's ducts should be cannulated to avoid injury.

Tracheostomy is probably unnecessary if the proper approach is chosen and surgical trauma and bleeding kept to a minimum. On the other hand tracheostomy will become necessary if intubation is difficult. Certainly, adequate drainage is a necessity and antibi-

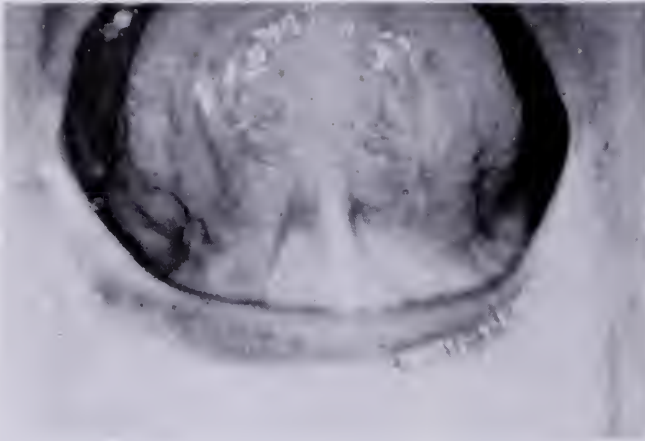


Fig. 5. — Postoperative normal submental profile.

otics and steroids are helpful. Tracheostomy preparation is highly recommended.

References

1. Jourdain, cited by Seward, G.T.: Dermoid Cysts of Floor of Mouth, *Brit. J. Oral Surg.* 3:36, 1965.
2. Butlin, H.T.: *Diseases of Tongue*, London, Cassel, 1885.
3. Colp, R.: Dermoid Cysts of Floor of Mouth, *Surg. Gynec. Obstet.* 40:183, 1925.
4. New, G.B. and Ench, J.B.: Dermoid Cysts of Head and Neck, *Surg. Gynec. Obstet.* 65:48, 1937.
5. Meyer, I.: Dermoid Cysts (Dermoids) of Floor of Mouth, *Oral Surg.* 8:1149, 1955.
6. Gold, B.D.; Sheinkopf, D.E., and Levy, B.: Dermoid, Epidermoid Teratomatous Cysts of Tongue and Floor of Mouth, *Oral Surg.* 32:107, 1974.

- Dr. Burnam, 8340 Northeast 2nd Avenue, Miami 33138.

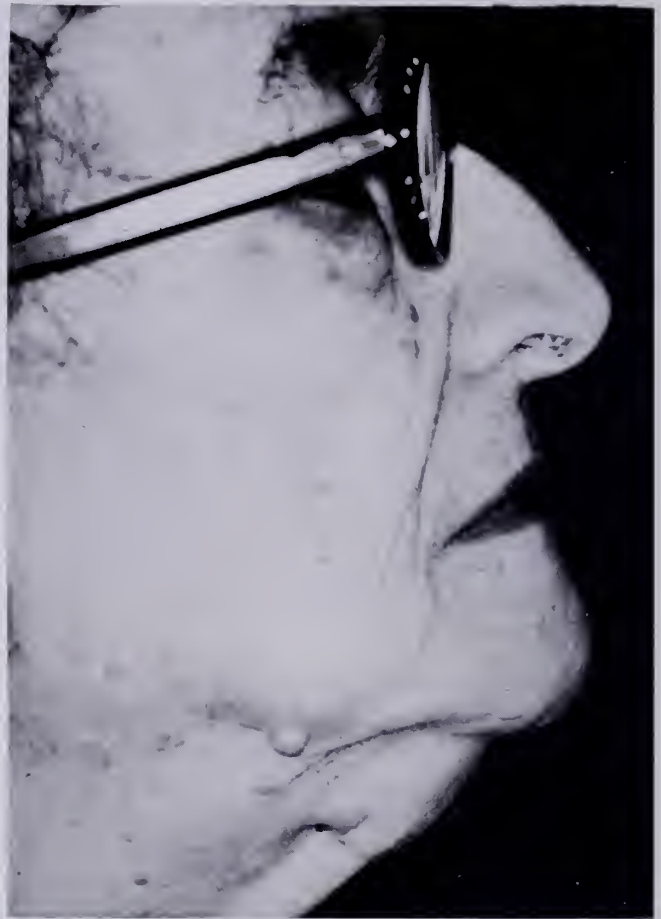


Fig. 6. — Postoperative normal intraoral cavity.

Worker's Compensation Revisited 1980

James F. Richards Jr., M.D.

During the past six years great strides have been made in Florida's Worker's Compensation Program (formerly Workmen's Compensation), despite efforts by some to convert the program into a poorly administered welfare program for injured workmen. Chapter 440 of the Florida Statutes states that physicians' reimbursement "... shall be limited to such charges as prevail in the same community for similar treatment of injured persons . . ." The physicians of Florida expected naively that the law meant it was the responsibility of the Division of Worker's Compensation to maintain a fee schedule for physicians' services that would compensate at the "prevailing level" in the community. In 1975, it became obvious that the Division of Worker's Compensation (the Bureau of Workmen's Compensation at that time) had no intention of maintaining a Medical and Surgical Fee Schedule that would accomplish our interpretation of the law. This placed the burden upon others to prove the necessity for an up-date in the Medical and Surgical Fee Schedule.

FMA's 1975 Petition

Therefore, in April of 1975, the FMA, in compliance with Florida's Administrative Procedures Act (APA), filed a petition with the Department of Commerce requesting an up-date in the Medical and Surgical Fee Schedule. Following this, a meeting was held with the Workmen's Compensation Advisory Council in May 1975 in Tallahassee. An additional meeting with representatives of the Bureau of Workmen's Compensation was held June 16, 1975 in Jacksonville. Three public

hearings, July 31, 1975, August 25, 1975, and December 18, 1975, were held in Tallahassee to review the Workmen's Compensation Medical and Surgical Fee Schedule. At these hearings, we presented testimony that proved the Fee Schedule should be up-dated to reflect usual and customary fees.

After the August 25 hearing, our petition was denied completely. The FMA appealed the decision to the First District Court of Appeals as outlined in the law. Upon this action, we were contacted by the Division of Labor and we agreed by joint stipulation to recall the appeal in order to allow an additional public hearing to be held on December 18, 1975.

Testimony presented by the Bureau of Workmen's Compensation at that hearing, was based upon the inflation rate as reflected in the Consumer Price Index from the time of the last increase until our petition of 1975. On Christmas Eve 1975, we were granted a 32% across the board increase, which went into effect March 1, 1976, representing an increase of approximately \$20 million per year for 3,500 physicians contributing to the care of injured workmen in the State. Although the specific requests of FMA were not granted, it was, nevertheless, the greatest single increase ever granted under the Workmen's Compensation Program up to that time. Medicine, radiology and pathology were pretty well brought up to our requests; surgery and anesthesiology were not. The Fee Schedule was published effective March 1, 1976.

Single Fee Schedule

While we had recommended to the Bureau that they might recognize several areas of the State, as were at that time recognized by Medicare, and grant varying fee schedules for the various areas of the State, the Bureau elected not to treat the State as separate areas, but as a single community. Therefore, the State was provided by the Bureau with a single fee schedule effective statewide.

The Author

JAMES F. RICHARDS JR., M.D.

Dr. Richards is Chairman of the FMA Committee on Worker's Compensation and is engaged in the private practice of orthopedic surgery in Orlando.

During the 1975 hearings, it was agreed by all that an annual up-date in the fee schedule would be desirable to avoid the need for large increases every few years that unfortunately generate great economic impact upon insurance premiums and cause a great deal of emotional response. The FMA left these hearings with expectations that an annual up-date would, indeed, be forthcoming.

Early in 1978, it became evident that an up-date in the Medical and Surgical Fee Schedule would not be initiated by the Bureau of Workmen's Compensation and, in fact, one of the Bureau's representatives stated that it would not be "politically expedient" for the Bureau to initiate an up-date, even though the law charges them with this responsibility.

The FMA began plans to file another petition to request an up-date, but we were advised by our Legislative Committees that the Workmen's Compensation Law would be "sunset" with major reform planned for the 1979 Legislative Session. It was felt that a request for an increase in the schedule at that time could have negative impact detrimental to the physicians of Florida. The Committee on Worker's Compensation recommended to the House of Delegates in 1979 that "...if no satisfactory adjustment is made in the Medical and Surgical Fee Schedule..." by the 1979 State Legislature a petition be initiated to request an increase. This course of action was adopted by the FMA House of Delegates.

Our 1979 Petition

No relief came through the Legislature, so on October 5, 1979, a petition was filed. The Committee on Worker's Compensation realized the need for an increase in the Fee Schedule as soon as possible, and therefore decided to use the precedent set in 1975 by the old Bureau of Workmen's Compensation to accomplish this. Plans also included beginning immediately a detailed analysis of the Fee Schedule for additional revision in the near future. A public hearing was held on December 10, 1979, in which the FMA presented testimony that the inflation rate since the last up-date request (April 1975) to August 1979 was 35%. No testimony in opposition was presented and the increase was granted in March to come effective July 1, 1980.

The 1980 Legislature reacted very strongly to the impact of a 35% increase in the fee schedule on Worker's Compensation insurance premiums. In fact, a bill was introduced to rescind the increase and freeze the level of reimbursement at the 1975 level. Thankfully, we were able to defeat this.

Other Worker's Compensation Improvements

During the same period of time other improvements in the Worker's Compensation Program were accomplished. At the time of the economic cutback in State government by former Governor Askew, all medical consultants for their Worker's Compensation Program were eliminated. This left the Bureau of Workmen's Compensation without medical input to evaluate the many complex Worker's Compensation claims for medical services. Only through the voluntary efforts of a few physicians around the State was the Bureau able to obtain assistance in medical evaluation of claims. This represented a great setback to the program.

The FMA successfully lobbied to create a position for a fulltime medical consultant and assisted the Division of Worker's Compensation (reorganized and renamed in the 1979 Law) in filling the position with Benjamin A. Johnson, M.D., formerly Associate Medical Director for Blue Shield of Florida. The FMA was also instrumental in amending the Worker's Compensation Law to include a Peer Review Program. Dr. Johnson's experience with the Medicare Peer Review Program, administered by Blue Shield, will prove invaluable in the establishment of a fair but effective Peer Medical Utilization Review Program. The FMA Board of Governors has just approved a contract with the Division of Worker's Compensation for Peer Review which should begin soon.

Annual Fee Review

Amendments to the Worker's Compensation Law adopted during the 1980 Legislative Session require an annual review of the fee schedule by a three-man panel. This guarantees that the fee schedule will be evaluated annually, but still allows us the right to petition for adjustments the FMA feels necessary but not recommended by the three man panel.

We have been working with the Division of Worker's Compensation in an effort to conform the Worker's Compensation Claim Form to the Uniform Claim Form of AMA. After petition and hearing, the Division accepted our recommendation to use the Uniform Claim Form with attachments on December 22, 1980, effective mid-January 1981.

We are also working with Dr. Ben Johnson to implement Peer Review in the program.

- Dr. Richards, 1315 South Orange Avenue, Suite D, Orlando 32806.

Being a deaf dancer is really something.



It looks like any other dance class. The dancers watch their movements in the mirror, giggle, make mistakes, master a position. Yet, Nancy Hlibok and the other students in this class at the Joffrey Ballet School are deaf. Physical response to the vibrations of the music, sign language and an inspiring teacher, Meredith Baylis, make it possible.

The students take pride in their dancing. All are lively and determined. Some would like to become professional dancers.

They probably will.

*We love the same country.
We care about the same things.
We dream the same dreams.
1981. The International Year
Of Disabled Persons.*

*President's Committee on
Employment of the Handicapped
Washington, D.C. 20210
The School of Visual Arts
Public Advertising System*





Tail of whipworm
(*Trichuris trichiura*)

Vermox[®]: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX [®]	68%*	93%**
Mintezol ¹	35%†	45%††
Antiminth ²	Not Indicated	
Povan ³	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX.[®]

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox[®] TABLETS
(mebendazole)



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

*Committed to research...
because so much remains to be done.*

© Janssen Pharmaceutica Inc. 1980

JPI-023



**Broad-spectrum
coverage in mixed
helminthic infections**

Vermox[®]
TABLETS
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX[®] in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX[®] in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S., and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

*Committed to research...
because so much remains to be done.*

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

MASTER APPROACH TO CARDIOVASCULAR PROBLEMS

Ninth Annual Conference

At

**The Contemporary Hotel
Walt Disney World Resort Complex**

Orlando, Florida

May 29 - 31, 1981

Guest Speakers:

Robert S. Eliot, M.D.
Mark E. Josephson, M.D.
Dennis Krikler, M.D.

University of Miami Faculty:

Agustin Castellanos, M.D.,
Bernard Fogel, M.D.,
Louis Lemberg, M.D., and
Robert J. Myerburg, M.D.

(For more information please call (305) 325-6411 or complete coupon and mail to: Y. Barcena, Cardiology (D-39), University of Miami School of Medicine, P. O. Box 016960, Miami, Florida 33101).

Please send me more information regarding
"MASTER APPROACH TO CV PROBLEMS"

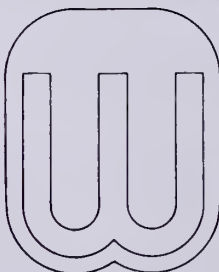
Name _____

Phone () _____

Address _____



**REINSURANCE
BROKERS for
Florida Physicians
Insurance Reciprocal
—serving physicians
throughout Florida**



**The
Wetzel
Company,
Inc.**



FMA AUXILIARY

Auxiliary Respects Time

The FMA Auxiliary is noted for its goals to promote better health through community service and support of research and education. Hard work is required to reach these goals, and work requires time. Time is one of our most precious commodities and wise time use is stressed in auxiliary programs. Members excel in enthusiastic dedication, but often suffer the disappointment of unrealized objectives because of time limitations. It can be frustrating, but Auxiliary has learned that it need not be defeating.

We have to adapt to time; it will not adapt to us. Time cannot be stretched like a rubber band. It cannot be banked or hoarded, nor can it be "saved". So-called time-saving devices merely free minutes for an individual to use in other ways. The Auxiliary refuses to be robbed of precious moments.

There are some obvious time thieves we must guard against.

Procrastination is that friendly little fellow who urges us to do the easy things first. He encourages us to put Auxiliary mail in a neat stack to tackle "tomorrow". If the deadline is June 1, he has a way of convincing us that June 3 is almost as good. The way to fight this charmer is to prioritize our tasks, by doing the most important ones first, handling papers only once, and making our personal deadline a few days earlier than the one required.

Over-involvement is the great flatterer who lures us into spreading ourselves thin over many projects or groups because this makes us feel sought-after and needed. Auxilians are urged to be selective in accepting volunteer work. No matter how impressive the job or title, the sweetness of belonging soon sours when we feel frazzled and do a less than adequate job. We are learning to say "no" nicely to commitments which rob us of time we need for more important things.

Inadequate planning is the ornery demon who prods us from task to task without organization or focused direction. Besides wasting time, this ogre makes us feel edgy and non-productive. He has met his match in the Auxiliary. Long-range planning is our motto on all levels. We have learned to plan by the year, month, and week. Individually we plan by the day, and even the hour, when necessary. Some use written schedules; others have mental checklists which are equally effective. Auxilians know that there is no excuse for being disorganized or losing time for lack of a plan.

Worry is the nastiest villain of all, the one who does the worst damage to the most people. He is the non-productive nag who saps our energy, makes difficulties seem insurmountable, and promotes depression. The Auxiliary is really on the warpath against this monster because he makes us unhappy, which in turn, demoralizes our families and friends. This negative creature wilts under positive action. That's what Auxiliary gives him — in extremely large doses. If there is a problem, we tackle it headon. We feel free to consult with our medical societies or the FMA. Auxilians are continually striving to distinguish between solvable problems and things which cannot be changed and thus do not deserve worry. After planning meetings and projects with our best efforts, we expect success. If Auxiliary experiences a less than smash hit, we learn from our mistakes and use them constructively. We can't waste time worrying about failures.

Auxiliary respects the time we have been given. We intend to persevere in searching for better ways to squeeze the most out of every minute.

Mrs. Fred P. Swing
President, FMAA
Port Charlotte

MAKE YOUR MARK AND BE COUNTED...

If you haven't already, now is the time to complete the 1981 Census of Physicians' Professional Activities.

Doing so will assure:

- that your official record is updated
- that you are accurately represented in the 28th Edition of the *American Medical Directory*
- that you continue to receive the educational and scientific materials relevant to your professional interests

Call or write if you have not received a census form

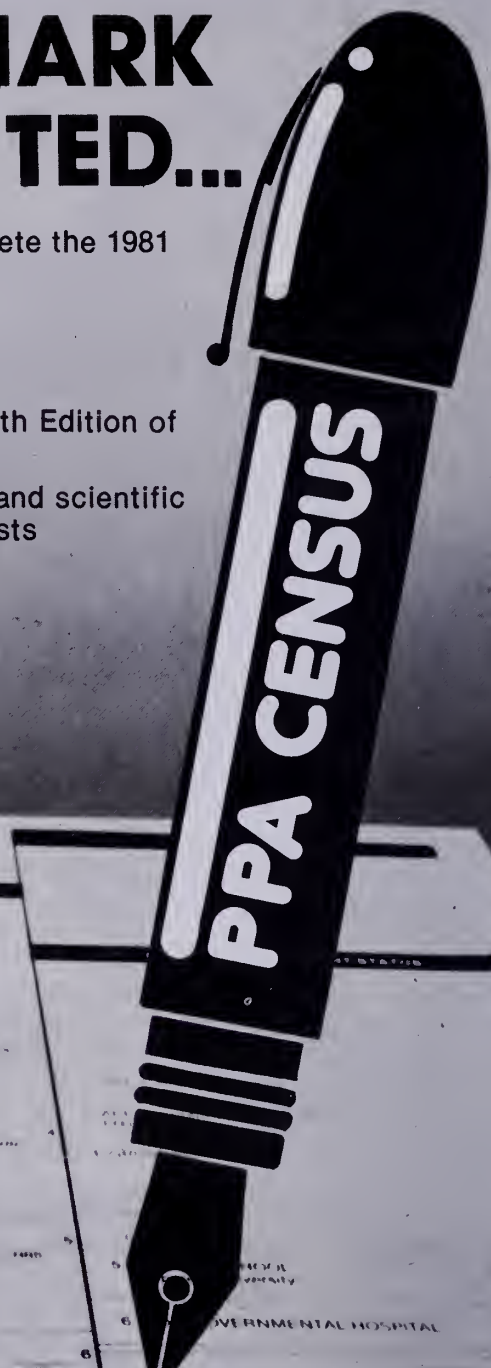
Division of Survey & Data Resources

American Medical Association

535 North Dearborn Street

Chicago, Illinois 60610

312-751-6435



1. How many hours per week do you spend on DIRECT CARE of Patients?

2. How many hours per week do you spend on ADMINISTRATIVE ACTIVITIES as a Salaried Staff Member or Executive of an Organization?

3. How many hours per week do you spend on MEDICAL TEACHING?

4. How many hours per week do you spend on MEDICAL RESEARCH?

5. How many hours per week do you spend on OTHER MEDICAL ACTIVITIES (not listed above) involving DIRECT CARE OF PATIENTS?

6. How many hours per week do you spend on OTHER MEDICAL ACTIVITIES (not listed above) NOT involving care of patients?

7. About how many hours per week do you spend in ALL PROFESSIONAL ACTIVITIES? For Residents, this is the total of questions 1, 5 and 6. For all other physicians this is the total of questions 2-7.

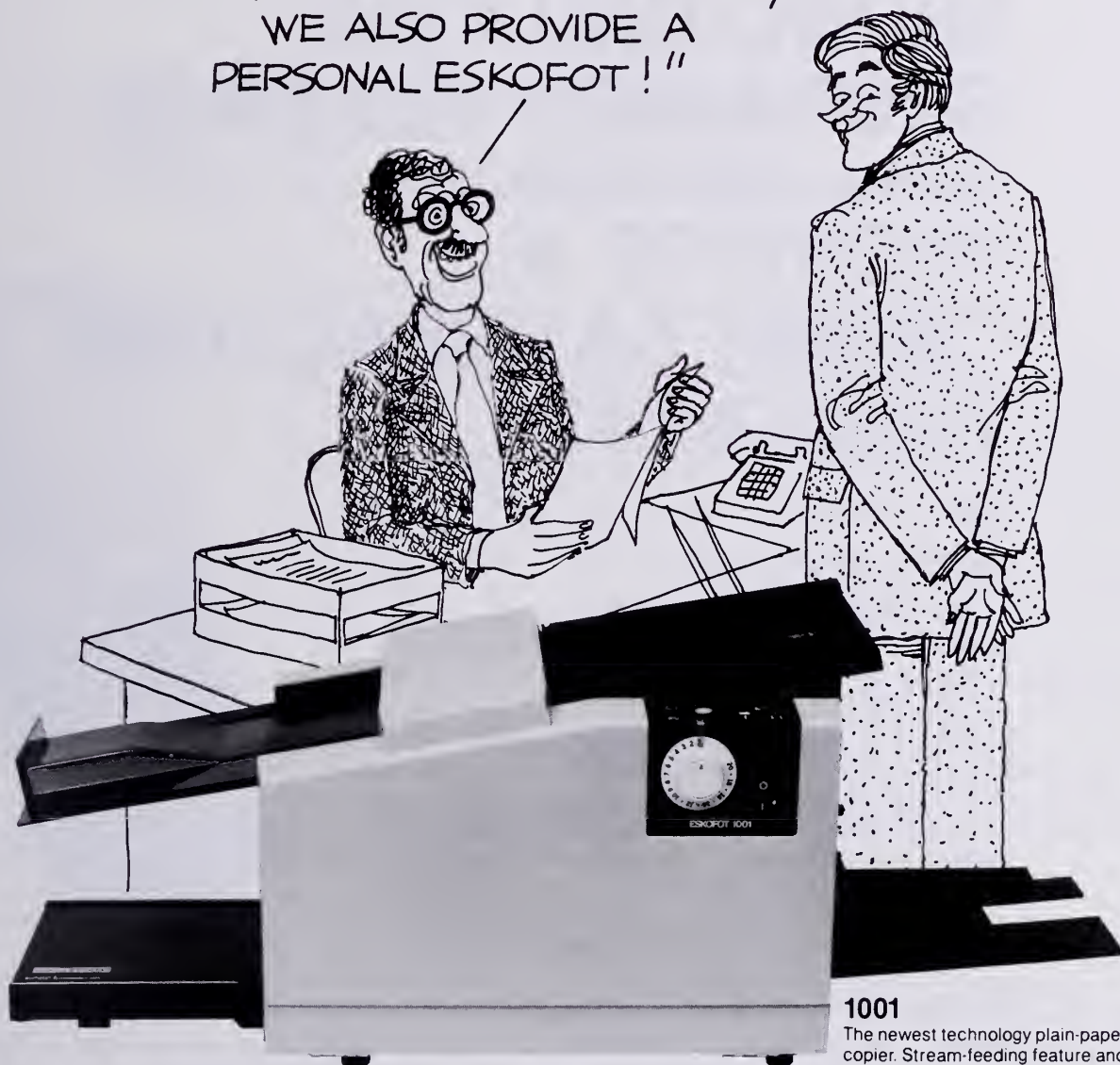
8. the TOTAL in question 7 above is 20 hours or less.

9. Indicate Federal Agency

10. OTHER ORGANIZATION - (all types of insurance carriers, pharmacies, corporations, voluntary organizations, societies, associations, grants, etc.)

Your best and brightest need to be your most productive. An Eskofot personal copier can help them reach their potential. Small savings of time (and harassment) add up to enormous increases in productivity. The new Eskofot 1001 is easy to use, convenient and designed (beautifully!) for key executive offices. Its unique stream-feeding feature lets you copy ten originals in the time it takes most machines to make ten copies of one original. The dry Eskofot 1001 uses any paper, too. And we mean *any* paper! Copy on memo stock, letterhead or the finest bond. Even labels and transparencies. Eskofot is truly the "any paper copier." You must have several people who deserve one. You need their brains on the job, not in the copy room. For the name of your nearest Eskofot dealer, call us at (800) 227-8989.

"AND FOR STANFORD MBA'S,
WE ALSO PROVIDE A
PERSONAL ESKOFOT!"



1001

The newest technology plain-paper copier. Stream-feeding feature and image-memory deliver sharp, dry copies from up to 10 different originals in one minute. Use any good quality bond paper — or even labels and transparencies.

THAT'S PRODUCTIVITY.
THAT'S BEAUTIFUL.
THAT'S GREAT DANISH DESIGN.

ESKOFOT

1001

FOR OPTIMUM NUTRITION

CEVI-BID

VITAMIN C MICRO-DIALYSIS SUSTAINED RELEASE 500mg. CAPSULES PROVIDES A "MORE SATISFACTORY TREATMENT..."¹

HERE'S WHY

ORDINARY VITAMIN C INTAKE:

Results in "peaks and valleys"

(wasteful renal excretions at high levels and less than optimum amounts of vitamin C at low levels)

Absorption of enteric-coated vitamin C tablets is also unpredictable.

"Through a special micro-dialysis release pattern we find it CEVI-BID far better therapy than tablets for the patient."²

CEVI-BID 500mg CAPSULES:

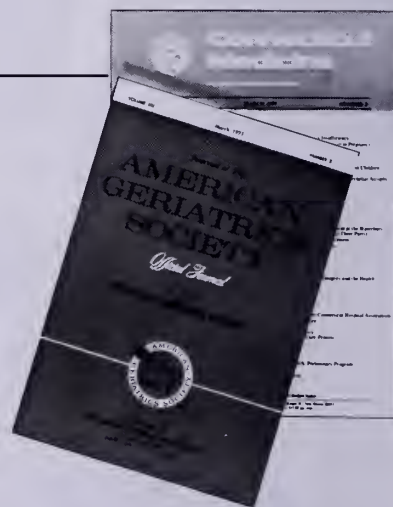
Convenient b.i.d. dosage for more predictable sustained vitamin C blood and tissue levels all day and night. No "peaks and valleys."

"A special advantage of this prolonged absorption period results in the maintenance of blood levels throughout the day and night."²

CEVI-BID's unique micro-dialysis principle provides release of 500mg of vitamin C during a 12 hour period

AT A SMOOTH, UNIFORM RATE.

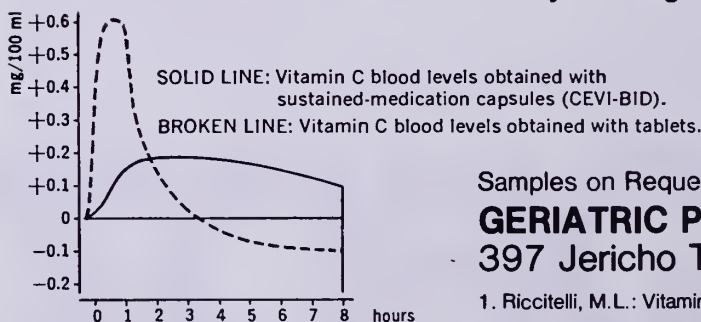
CEVI-BID... "provides a more satisfactory treatment of disorders requiring administration of vitamin C in repeated doses of relatively small amounts."¹



WHENEVER VITAMIN C IS INDICATED...PRESCRIBE CEVI-BID

Dosage: For continuous 24 hour therapy, one capsule after breakfast and one after supper.

Available Only Through The Medical Profession



*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules).
*Adaptation

Samples on Request

GERIATRIC PHARMACEUTICAL CORP.

397 Jericho Turnpike, Floral Park, N.Y. 11001



1. Riccitelli, M.L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20:34, 1972.

2. Riccitelli, M.L.: Vitamin C—A Review. Conn. Med. 39:609, 1975

DEVELOPERS AND SUPPLIERS OF GER-O-FOAM • GAYSAL • B-C-BID

ORGANIZATION

Annual Meeting Scientific Program Offers Something for Everyone



Dr. Trainer

A well-balanced scientific program that offers something for everyone attending the 107th Annual Meeting of the Florida Medical Association is shaping up.

And the FMA Committee on Continuing Medical Education points out that the scientific program represents a real bargain. FMA members can pick up as many as 20 AMA Category I CME hours for no tuition or registration fee whatever.

It's a valuable membership benefit, and no advance registration is required for admission to the program.

Theme for this year's session at the Diplomat Hotel in Hollywood from April 29 to May 3 is "Stress and Lifestyle." Joseph B. Trainer, M.D., of Portland, Oregon, will keynote the theme with an address entitled "Stresses on the Medical Family" on Thursday evening, April 30.

According to Calvin W. Martin, M.D., of Arcadia, Annual Meeting Program Chairman, Dr. Trainer also has accepted an invitation to present a paper before the Section on Family Medicine earlier that day. His talk to the Section is called: "Saving Your Life".

Dr. Martin said the following scientific sections have been announced in recent weeks by the various FMA-recognized specialty groups:

WEDNESDAY AFTERNOON, APRIL 29

SECTION ON PEDIATRIC CARDIOLOGY AND NEONATAL-PERINATOLOGY

(Co-sponsored by Florida Association of Pediatric
Cardiologists and Florida Society of
Neonatal-Perinatologists)

1:00 p.m. to 4:15 p.m.

Jeane McCarthy, M.D., St. Petersburg
Program Chairman

"Bedside Use of Ultrasound in the Neonatal Intensive Care Unit" — Hugh Allen, M.D., Teaching Scholar of the American Heart Association, and Professor of Pediatrics, and Director of the Echocardiography Laboratory, University of Arizona Medical Center, Tucson, Arizona.

"Prostaglandins: An Overview" — Jeane McCarthy, M.D., Ph.D., Neonatologist, All Children's Hospital, St. Petersburg.

"Palliation of Congenital Heart Disease with Prostaglandins" — Art Pickoff, M.D., Assistant Professor of Pediatrics, Division of Cardiology, University of Miami School of Medicine, Miami.

"Prostacyclin and Persistent Fetal Circulation" — Willa Drummond, M.D., Assistant Professor of Pediatrics, University of Florida College of Medicine, Gainesville.

SECTION ON INTERNAL MEDICINE

(Co-sponsored by Florida Society of Internal Medicine
and Florida Region, American College of Physicians)

1:00 p.m. to 4:15 p.m.

Roy H. Behnke, M.D., Tampa
Program Chairman

"Stress as a Component of Disease"

"The Dynamics of Stress" — Anthony J. Readking, M.D., Professor and Chairman, Department of Psychiatry, University of South Florida College of Medicine, Tampa.

"Asthma" — Samuel C. Bukantz, M.D., Professor of Medicine, Division of Allergy and Clinical Immunology, Department of Internal Medicine, University of South

Florida College of Medicine, Tampa.

"Hyperventilation Syndrome" — David A. Solomon, M.D., Associate Professor of Medicine, Division of Pulmonary Disease, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

"Hypertension" — Celso Gomez-Sanchez, M.D., Associate Professor of Medicine, Division of Endocrinology and Metabolism, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

"Acid Peptic Disease" — Heinz Juergen Nord, M.D., Associate Professor of Medicine, Division of Digestive Diseases and Nutrition, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

"Functional Bowel Disease" — H. Worth Boyce, M.D., Professor of Medicine, Division of Digestive Diseases and Nutrition, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

"Dermatologic Stress Related Disorders" — Neil A. Fenske, M.D., Assistant Professor of Medicine, Division of Dermatology, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

THURSDAY AFTERNOON, APRIL 30

SECTION ON ORTHOPEDIC SURGERY (SECTION I)

(Co-sponsored by Florida Orthopedic Society)

1:30 p.m. to 5:30 p.m.

George J. Fipp, M.D., Jacksonville

Program Chairman

Program to be Announced

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Society of Rheumatology)

1:30 p.m. to 4:30 p.m.

Robert Thoburn, M.D., Gainesville

Program Chairman

"Role of Hist-Compatibility Markers in the Study and Diagnosis of Rheumatic Diseases" — Claude Bennett, M.D., Professor and Chairman of the Department of Microbiology, and Director of the Division of Immunology and Rheumatology, University of Alabama School of Medicine, Birmingham, Alabama.

"Clinical Significance of Rheumatoid Factors" — Claude Bennett, M.D., Birmingham, Alabama.

"Vasculitis Syndromes" — Paul Katz, M.D., Assistant Professor of Medicine, Division of Rheumatology, University of Florida College of Medicine, Gainesville.

"Low Back and Leg Pain: Modern Concepts in Therapy" — Joseph Cauthen, M.D., Clinical Associate

Professor of Neurological Surgery, University of Florida College of Medicine, and Private Practice, Gainesville.

SECTION ON FAMILY PRACTICE

(Co-sponsored by Florida Academy of Family Physicians)

2:00 p.m. to 5:00 p.m.

Bernard Breiter, M.D., Daytona Beach

Program Chairman

"Saving Your Life" — Joseph B. Trainer, M.D., Clinical Professor of Preventive Medicine and Public Health, University of Oregon Health Science Center, Portland, Oregon.

"The Family Doctor and the Hospice — Experience of Nine Months in Florida's First Comprehensive Hospice" — Clyde M. Collins, M.D., Medical Director, Hospice of Methodist Hospital, Jacksonville.

"Animal Transmitted Diseases" — Oscar Sussman, D.V.M., Associate Epidemiologist/Veterinarian, Florida Health Program Office, Tallahassee.

FRIDAY MORNING, MAY 1

SECTION ON CHEMICAL DEPENDENCY

(Co-sponsored by Florida Medical Foundation Committee on Impaired Physicians)

8:00 a.m. to 10:45 a.m.

Dolores A. Morgan, M.D., Miami

Program Chairman

Welcome — Guy T. Selander, M.D., Chairman, Florida Medical Foundation Committee on Impaired Physicians, Jacksonville.

"Identification and Motivation of the Chemically Dependent Physician" — G. Douglas Talbott, M.D., Program Director, Georgia's Disabled Doctors Program, Smyrna, Georgia.

"The Addict and Alcoholic of the 1980s" — Dolores A. Morgan, M.D., Medical Director, Florida Medical Association/Foundation Impaired Physicians Program, Miami.

"Prescription Drug Abuse with Review of Education and Treatment Alternatives" — David Smith, M.D., San Francisco, California.

SECTION ON ORTHOPEDIC SURGERY (SECTION II)

(Co-sponsored by Florida Orthopedic Society)

8:30 a.m. to 10:45 a.m.

George J. Fipp, M.D., Jacksonville

Program Chairman

"Intraarticular Distal Humeral Fractures — Open Reduction" — John Jennings, M.D., Miami.
"Orthopedic Aspects of Common Dystrophies" — Michael S. Gurvey, M.D., Miami.
"Treatment of Dural Tears Associated with Spine Surgery" — Frank Eismont, M.D., Miami.
"What's Going on Out There?" — Michael Alms, M.D., Santo Domingo, D.R.

FRIDAY AFTERNOON, MAY 1

SECTION ON ENDOCRINOLOGY AND GASTROENTEROLOGY

(Co-sponsored by Florida Endocrine Society and
Florida Gastroenterologic Society)

2:00 p.m. to 6:00 p.m.

Paul S. Jellinger, M.D., Hollywood
Stephen B. Novak, M.D., Hollywood
Arvey I. Rogers, M.D., Miami
Program Co-Chairmen

Program to be Announced

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon
and Rectal Surgeons)

2:00 p.m. to 6:00 p.m.

Shed Roberson, M.D., Daytona Beach
Program Chairman

"Experience with the Short Colonoscope in Clinical Practice" — H. Whitney Boggs, M.D., Shreveport, Louisiana.

"Clinical Gastroenterology for the Colo-Rectal Surgeon" — Henry W. Boyce, M.D., Tampa.

"Anorectal Problems" (Panel)

Moderator:

Shed Roberson, M.D., Daytona Beach

Panelists:

H. Whitney Boggs, M.D., Shreveport, Louisiana

Emmett Ferguson, M.D., Jacksonville

Matthew Larkin, M.D., Miami

Albert G. Biehl, M.D., Boca Raton

"Pre-op Irradiation for CA of Rectum" — Shed Roberson, M.D., Daytona Beach.

George J. Fipp, M.D., Jacksonville
Program Chairman

"Concepts in Management of Severe Open Tibial Fractures Utilizing External Fixation and Cast Brace" — John Nordt, M.D., Miami.

"Operative Treatment of Thoracic-Lumbar Fractures" — Richard Ganzhorn, M.D., Russell Clark, M.D., and Howard Hogshead, M.D., Jacksonville.

"Running Injuries" — Russell Clark, M.D., Jacksonville.

"What Should We Teach Them?" — Michael Alms, M.D., Santo Domingo, D.R.

SECTION ON SURGERY

(Co-sponsored by Florida Chapter,
American College of Surgeons)

8:00 a.m. to 12:00 noon

Arthur K. Waltzer, M.D., Tampa
Program Chairman

**"Multidisciplined Approach to Trauma —
Changing Concepts"**

"Recent Advances in Neurosurgery" — Gene Balis, M.D., Tampa.

"Recent Advances in the Management of Facial Injuries" — Joel Mattison, M.D., Tampa.

"Pulmonary Complications in the Traumatized Patient" — Alan Goldman, M.D., Tampa.

"Resuscitation and Current Concepts in the Diagnosis of Abdominal Trauma" — Arthur K. Waltzer, M.D., Tampa.

"Management of Orthopedic Injuries" — Philip Spiegel, M.D., Tampa.

"Management of Injuries to the Urinary Tract" — Steven Woodrow, M.D., Tampa.

SECTION ON NEUROLOGY AND NEUROSURGERY

(Co-sponsored by Florida Society of Neurology and
Florida Neurosurgical Society)

9:00 a.m. to 12:00 noon

B. L. Bercaw, M.D., Clearwater

Gaston J. Acosta-Rua, M.D., Jacksonville
Program Co-Chairmen

"Pituitary Surgery on Disorders of the Pituitary Gland" — Albert L. Rhoton, Jr. M.D., Professor and Chairman, Department of Neurological Surgery, University of Florida College of Medicine, Gainesville.

"Amenorrhea, Galactorrhea and Prolactin Secreting Tumors" — Frank C. Rigall, M.D., Assistant Professor of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville.

SATURDAY MORNING, MAY 2

SECTION ON ORTHOPEDIC SURGERY (SECTION III)

(Co-sponsored by Florida Orthopedic Society)
8:00 a.m. to 10:45 a.m.

"Neuroradiologic Aspects of Pituitary Tumors" — O. Frank Agee, M.D., Professor of Radiology, University of Florida College of Medicine, Gainesville.

"Neuroophthalmic Aspects of Sellar Tumors" — Jonathan D. Trobe, M.D., Assistant Professor of Ophthalmology, University of Florida College of Medicine, Gainesville.

"Endocrinologic Aspects of Pituitary Tumors" — Peter W. Stacpoole, M.D., Department of Medicine, University of Florida College of Medicine, Gainesville.

SATURDAY AFTERNOON, MAY 2
SECTION OF INTERNATIONAL
COLLEGE OF SURGEONS

(Co-sponsored by Florida State Surgical Division,
International College of Surgeons)

1:30 p.m. to 2:30 p.m.

Robert H. Hux, M.D., Leesburg
Program Chairman

"Acute Arterial Occlusion: Diagnosis and Management" — Andrew Sharf, M.D., Past President, United States Section, International College of Surgeons, Glendale, California.

Correction

An article in the January issue of *The Journal* gave the incorrect date for the Section on Physical Medicine and Rehabilitation at the 107th Annual Meeting of the Florida Medical Association.

The Section is scheduled for 10:00 a.m. to 12:00 noon on *Saturday, May 2* — not on Friday, May 1 as indicated on page 50 of the January issue.

Leadership

**It took time to achieve it
It takes dedication to keep it**

Purepac became the largest generic drug manufacturing facility in the United States by providing high quality generic pharmaceuticals at the lowest possible cost. We know that to be on top tomorrow, we've got to stay a few steps ahead today. Here are some of the steps we've already taken:

- ▶ **Full-time Medical Vice President with Supporting PhD Staff**
- ▶ **ANDA/Patent Review Departments**
- ▶ **State Formulary Manager**
- ▶ **Regulatory Affairs Department**
- ▶ **Comprehensive Advertising and Marketing Support Programs**

It took Purepac 50 years to achieve this leadership position. And we're determined to provide you with even more quality products and dedicated services in the next 50 years.



PUREPAC PHARMACEUTICAL CO.

Division of Kalipharma, Inc., Elizabeth, N.J. 07207

1930-1981

Celebrating over 50 years of industry leadership.



**The Florida Medical Association, Inc.
and
The Florida Medical Foundation**

**COMMITTEE ON
IMPAIRED PHYSICIANS**

Is Pleased to Announce the Installation of
Its Telephone Hot Line

Call

(305) 667-8717

. . . if you know a physician with an alcohol or
other drug related problem.

Guy T. Selander, M.D.
Jacksonville
Chairman

Dolores A. Morgan, M.D.
Miami
Medical Director



Dr. Caranasos

Another endowed professorship . . . has been established at the University of Florida College of Medicine.

George J. Caranasos, M.D., a member of the UF faculty for 13 years, was appointed to the new professorship of medicine in geriatrics. The position was established through a gift by **Ruth S. Jewett, M.D.**, of Winter Park, a pioneer in treating diseases of the elderly.

A graduate of the Johns Hopkins University Medical School, Dr. Caranasos has an extensive background in geriatrics. He directs a clinic for elderly residents of the Gainesville Housing Authority apartments and is co-director of a fellowship training program in geriatrics at the Gainesville VA Hospital.

Franklin B. McKechnie, M.D. . . . of Winter Park, has been re-elected Speaker of the House of Delegates of the 16,800-member American Society of Anesthesiologists.

Dr. McKechnie is Vice Speaker of the House of Delegates of the Florida Medical Association and is a past President of the Florida Society of Anesthesiologists. He received his M.D. degree in 1945 from Johns Hopkins.

Mr. Philip H. Gilbert of the FMA staff...has assumed the position of Director of Medical Economics at the FMA Headquarters Office in Jacksonville. Mr. Gilbert was previously Director of Government Programs at the FMA Capital Office in Tallahassee, and was responsible for implementing FMA efforts in health planning. Since joining the FMA in 1973, Mr. Gilbert has served as Director of Scientific Activities, and Director of Medical Services.

The position of Director of Medical Economics was formerly held by **Mr. John B. Richardson**, who resigned to assume the duties as Executive Director of Hillsborough County Medical Association, effective January 1, 1981.

American Hospital of Miami . . . has been accredited for continuing medical education by the FMA Committee on CME. **Samuel E. Crockett, M.D.**, Chairman of the FMA Subcommittee on Accreditation, said the program was certified for a provisional period of two years, retroactive to September 24, 1980, when an on-premises survey was conducted by the Committee.

At its meeting in December, the FMA Committee on CME also reaccredited the programs of Sarasota County Medical Society, the Florida Academy of Family Physicians, Hollywood Memorial Hospital, and Orlando Regional Medical Center, for four years each.

The Committee's accreditation authority is derived from the American Medical Association. CME accreditation authorizes hospitals and others to sponsor or co-sponsor educational activities and designate AMA Category I Credit, if indicated.

Sixteenth Annual Postgraduate Course

"INTERNAL MEDICINE 1981"

February 28 — March 6, 1981

SHERATON BAL HARBOUR HOTEL

MIAMI BEACH, FLORIDA

The object of this course, the sixteenth in its series, is to provide an annual updating of the most useful recent advances in the diagnosis and management of internal medical disorders as they are encountered by primary care physicians and practicing specialists.

GUEST FACULTY

PETER T. MACKLEM, M.D.

Professor of Medicine and Chairman
Department of Medicine
McGill University
Montreal, Canada

EDGAR HABER, M.D.

Professor of Medicine
Harvard Medical School
Boston, Massachusetts

LOUIS WEINSTEIN, M.D.

Visiting Professor of Medicine
Harvard Medical School, Physician
Peter Bent Brigham Hospital
Boston, Massachusetts

SOLOMON PAPPER, M.D.

Distinguished Professor of Medicine and
Head of the Department of Medicine
University of Oklahoma
Oklahoma City, Oklahoma

J. WILLIS HURST, M.D.

Professor and Chairman
Department of Medicine
Emory University School of Medicine
Atlanta, Georgia

HIGHLIGHTS

**VIDEOTAPES OF TOPICS
FOR BOARD REVIEW IN
INTERNAL MEDICINE**

Selected topics in Internal Medicine updated by the University of Miami faculty and primarily designed for physicians preparing for Board certification in Internal Medicine will be video-taped in the evenings.

TWO MAJOR SYMPOSIUMS

Two major symposiums presenting "Management of the Medical Office" & "Cardiopulmonary Resuscitation" will be new features of the scientific activities.

**MEET THE FACULTY SESSIONS
"CRITICAL CARE IN
INTERNAL MEDICINE"**

Simultaneous group meetings will present topics of Critical Care in Internal Medicine. Special emphasis will be given to the most recent advances in the management of the critically ill patient.

STATE OF THE ART LECTURES • AUDIO VISUAL AIDS • SCIENTIFIC EXHIBITS

HOTEL ATTRACTIONS • SOCIAL ACTIVITIES

35 LECTURE HOURS AND 20 SELF-INSTRUCTION HOURS OF CREDIT, CATEGORY I, AMA

Registration: \$400/Physicians

\$250/Physicians-in-Training*

*Letter from Chief of Service must accompany registration.

**For Registration and
Information Write to:**

Jose S. Bocles, M.D.
Department of Medicine R760
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101
Phone: (305) 547-6063



Correspondence

EARLY MEDICINE IN FLORIDA

To the Editor: In doing some research for a talk that I was to give about early medicine in Florida, I found a startling bit of information. I had always assumed that the first medicine practiced in the United States, other than that done by the Indian medicine man, had been at St. Augustine, which was settled by the Spanish in 1565.

The quote which was such a surprise is from a letter to Phillip II of Spain from Pedro Menendez dated October 15, 1565, and is as follows: "There were found, counting women, girls and boys under 15 years, about 50 persons, and very great is my anxiety at seeing them in the company of my people, because of their evil sect, and I feared our Lord would punish me if I used cruelty towards them, for eight or ten of the boys were born here."

The above quote pertains to the capture of Fort Caroline near the mouth of the St. Johns River which had been settled June 25, 1564, by Rene de Laudonniere with 300 colonists, mostly Huguenots. It is apparent from the above quote that the first obstetrics other than by native Indians in the United States was done in the vicinity of Fort Caroline 1564-65. Whether these deliveries were done by physicians or midwives perhaps can be established by research . . . The information secured from Pedro Menendez . . . gives adequate proof that Jacksonville should be the site for historic medicine not only for the State of Florida but also for the United States.

*O. E. Harrell, M.D.
Jacksonville*

HISTORICAL EDITOR COMMENTS FURTHER

To the Editor: You invited my comments upon the letter by Dr. O. E. Harrell concerning the site of the earliest practice of medicine (obstetrics) in Florida and the United States. To begin with, in 1966 I obtained some correspondence from Mr. Charles E. Bennett, the author

of the reference that Dr. Harrell is using, in which he stated he was not certain whether a physician was present in the Huguenot colony or whether such medicine as was practiced was carried out by an apothecary. Mr. Bennett mentioned that he had used the word physician on the basis of a type script translation of an account by Laudonniere but that this type script had unfortunately been lost and he had no way to reinvestigate the matter. Therefore it does not seem established that a physician or barber surgeon was in the Huguenot colony during its existence on the St. Johns River.

Prior to the establishment of the Huguenot colony on the St. Johns River there were at least five Spanish expeditions into Florida and since these were well financed by the Crown it seems likely they carried with them barber surgeons. Indeed, in the account of the de Soto expedition which landed at Tampa Bay May 18, 1539, there is mention of at least one barber surgeon. We also know that an Indian Chief in what is now Alachua County struck de Soto knocking out several of his teeth and badly bruising his face in 1539. Certainly the leader of the expedition would have had the services of the barber surgeon or surgeons in such a situation. It also seems likely that Ponce de Leon who attempted a settlement in February 1521, at what is now Charlotte Harbor had at least one barber surgeon with his 200 settlers and his small army. However, the extant accounts do not mention a barber surgeon. Similarly I have not been able to find mention of a surgeon with Tristan de Luna expedition (August 14, 1559) which landed at Pensacola Bay but it seems likely one was present.

Therefore I cannot say with certainty where or when the first European physician practiced medicine in Florida or the Continental United States but I suspect it was prior to the establishment of Fort Caroline.

*William M. Straight, M.D.
Historical Editor
Miami*

**When painful spasm
is the presenting
symptom...**

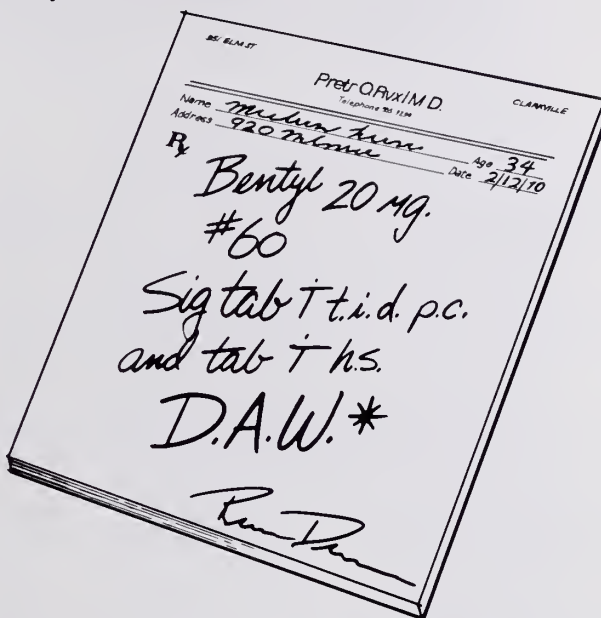


...in the functional bowel/irritable bowel syndrome[†]

be sure to specify

Bentyl[®]
(dicyclomine
hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injectable



**D.A.W.-Dispense as written*

because:

Bentyl passes these tests for product integrity.

- ⊕ The Bentyl molecule is a product of original Merrell research.
- ⊕ At Merrell, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable.
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablets, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Pharmacologic effect in the distal colon compared to placebo^{††} shows how Bentyl affects abnormal motor activity in the irritable colon patient.[†]

[†]This drug has been classified "probably" effective for this indication.

Merrell

^{††} In the experiments that showed significant pharmacologic effect, the dose of Bentyl used was 50 mg. I.M., which is higher than that permitted in the labeling. This dose was deemed justified since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level that occurs after a single 50 mg. I.M. dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis, toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/ antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

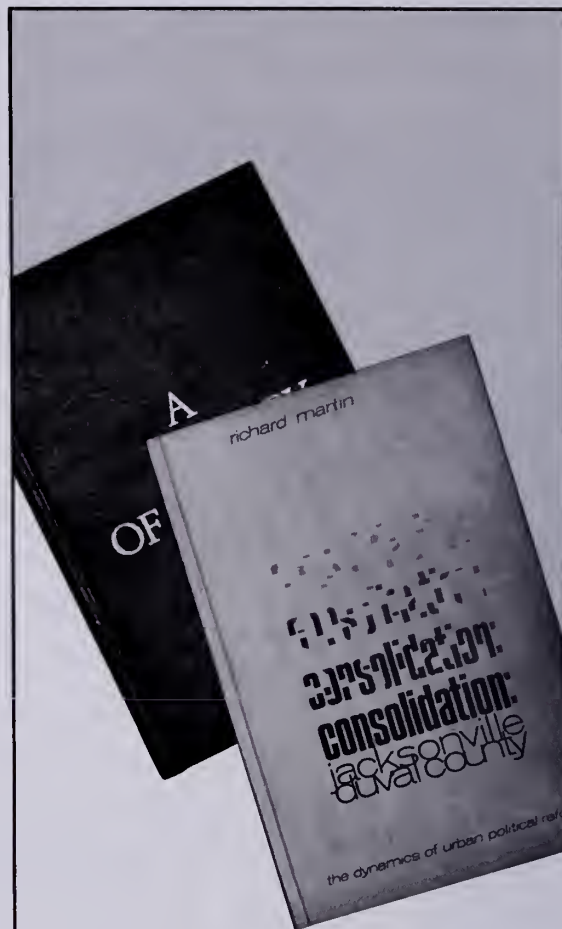
MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACAL COMPANY
Ocaturo, Illinois 62525 for
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Merrell

0-6546 (Y115C) MNQ 442



Distinctive Books For Professionals

Since 1964 publishers of quality case
bound and perfect bound books in
such diverse fields as Education,
Medicine, Politics and Art.

For information on producing your
book contact:

CRAWFORD PUBLISHING COMPANY

2111 North Liberty Street
Jacksonville, Florida 32206
Telephone 904/354-5555

A Division of Convention Press, Inc.

MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

MARCH

Being an Effective Clinical Teacher, Mar. 2-6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Comprehensive Review in Basic Neurology for Psychiatrists and Generalists, Mar. 2-6, Konover Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Postgraduate Medical Refresher Course, Mar. 2-13, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Donald R. Lannin, M.D., 832 Central Medical Building, St. Paul, Minnesota 55104.

Internal Medicine Update '81, Mar. 2-7, Dutch Resort Hotel, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1414 S. Kuhl Ave., Orlando 32806.

Intensive Care for Neurological Trauma and Disease, Mar. 4-7. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Issues in the Psychotherapy of Women, Mar. 5, Williamson's Restaurant. For information: Peggy Jackson, ACSW, 330 S.W. 27th Avenue, Ft. Lauderdale 33315.

Developmental Disabilities and Pediatric Practice, Mar. 5-7, Sheraton and Sand-Key Hotel, Clearwater Beach. For information: Mary G. Tenne, AAP, P.O. Box 1034, Evanston, Illinois 60204.

Oculoplastic-Orbital Update, Mar. 5-7, University of South Florida College of Medicine, Tampa. For information: James A. Rush, M.D., Box 21, 12901 N. 30th Street, Tampa 33612.

1981 Cardiology at the Dark Continent, Mar. 6-7, Holiday Inn Airport, Tampa. For information: Stephen P. Glasser, M.D., University of South Florida College of Medicine, 12901 North 30th Street, Tampa 33612.

Problems in Rheumatology, Mar. 11-14, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bernard F. Germain, M.D., Assistant Professor of Medicine, Director, Division of Rheumatology, Box 19, University of South Florida College of Medicine, 12901 North 30th Street, Tampa 33612.

Postgraduate Seminar in Dermatology, Mar. 12-14. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Management of the Acutely Ill Patient, Mar. 14, Watson Clinic Library, Lakeland. For information: John A. Bazley, M.D., 1600 Lakeland Hills Boulevard, Lakeland 33802.

Non-Invasive Evacuation of Peripheral and Cerebral Vascular Disease, Mar. 17, Dodger Pines, Vero Beach. For information: Ferdinand Becker, M.D., 777 37th Street, Vero Beach 32960.

"Migraine: Diagnosis and Management", Mar. 17, Martin Memorial Hospital, Stuart. For information: Charles A. Fraraccio, M.D., 931 East Ocean Boulevard, Stuart 33494.

Orthopaedics for Family and Emergency Physicians, Mar. 18-21, Royal Plaza Hotel, Lake Buena Vista. For information: Allan W. March, M.D., Box J-222, JHM Health Center, Gainesville 32610.

Infectious Disease and Chemotherapy for the Practicing Physician 1981, Mar. 19-21, Dutch Resort Hotel, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1414 S. Kuhl Avenue, Orlando 32806.

Controversies in Critical Pulmonary Care — 1981, Mar. 21-22, Don Cesar Beach Resort, St. Petersburg. For information: Daniel J. Schwartz, M.D., 13000 North 30th Street, Tampa 33612.

"Controversies in Pulmonary Medicine", Mar. 21-22, Don Cesar Beach Resort, St. Petersburg. For information: Daniel J. Schwartz, M.D., Pulmonary Disease Section (111C), 13000 North 30th Street, Tampa 33612.

Pediatric Orthopedics for Family Practitioners and Pediatricians, Mar. 22-25, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

American and European Views on Anesthesia, Mar. 22-27, Zermatt, Switzerland. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Current Clinical Concepts in Otolaryngology (in English and Spanish), Mar. 23-25, Eden Roc Hotel, Miami. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Postgraduate Course on Pediatric Orthopaedics for Family Practitioners and Pediatricians, Mar. 23-25, Sheraton Bal Harbour, Hotel, Miami Beach. For information: Anthony Ballard, M.D., Course Chairman, Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Box 016960, Miami 33101.

Chronic Liver Disease: Toxic, Metabolic, and Alcoholic Injury. A Practical Approach to Assessment and Treatment, Mar. 26, University of South Florida, Tampa. For information: H. Worth Boyce Jr., M.D., 12901 North 30th Street, Tampa 33612.

Toxic and Metabolic Liver Injury, Mar. 26, University of South Florida Medical Center, Tampa. For information: H. Worth Boyce, M.D., 12901 North 30th Street, Box 19, Tampa 33612.

Alert and
functioning
in the
sunset
years

Treat the symptoms in
the geriatric patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule contains:

Pentylentetrazole100 mg.
Nicotinic Acid100 mg.
Ascorbic Acid100 mg.
Thiamine HCL25 mg.
L-Glutamic Acid50 mg.
Niacinamide5 mg.
Riboflavin2 mg.
Pyridoxine HCL3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Interesting Topics in Orthopedics, Mar. 26-28, Hyatt Palm Beaches, West Palm Beach. For information: H. Worth Boyce, M.D., 12901 North 30th Street, Box 19, Tampa 33612.

12th Annual Topics in Internal Medicine, Mar. 26-28, Gainesville Hilton, Gainesville. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Pan American Symposium on Trauma of Head and Neck (in English and Spanish), Mar. 26-28, Eden Roc Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

A Noninvasive Approach to the Cardiac Patient, Mar. 28-29, Sheraton Inn, Pensacola. For information: Cardiology Associates, 1717 North "E" Street, Suite 503, Pensacola 32501.

Oncology in General Practice, 2nd Annual Conference, Mar. 30-Apr. 8, Aboard SS. Doric in the Caribbean Sea. For information: Peter W. A. Mansell, M.D., Comprehensive Cancer Center D8-4, University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

"An International Conference on Gerontology", Mar. 29-Apr. 3, Sheraton Bal Harbour Hotel, Miami Beach. For information: Office of Planning, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach, 33140.

APRIL

Hypertension and Cardio-renal Function in the Elderly, Apr. 2-3, Konover Hotel, Miami Beach. For information: Barry J. Materson, M.D., 1201 Northwest 16th Street, Miami 33125.

"Crisis Control Workshop", Apr. 3, Harley's Sunrise Inn, Ft. Lauderdale. For information: Cathryn Liberson, Ph.D., 2101 North 37th Avenue, Hollywood 33021.

Clinical Management of Coronary Disease & Exercise Testing, Apr. 3-5, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive, East, Englewood, Colorado 80112.

Advanced Cardiac Life Support, Apr. 4-5, Pasco-Hernando Community College, New Port Richey. For information: James M. Marlowe, M.D., P.O. Box 1058, New Port Richey 33552.

Comprehensive Review Course: ECFMG, VQE, and FLEX (in Spanish), Apr. 6-July 17, UM/Jackson Memorial Hospital, Miami. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Critical Care Medicine '81, Apr. 9-11, Dutch Resort Hotel, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1414 S. Kuhl Ave., Orlando 32806.

Family Practice Weekend, University of Florida, Apr. 10-12, J. Wayne Reitz Union and Gainesville Holiday Inn, Gainesville. For information: E. Scott Medley, M.D., 625 Southwest 4th Avenue, Gainesville 32601.

Atrial and Ventricular Arrhythmia Management Update, Apr. 16-18, Belview Biltmore, Clearwater. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Update on Current Topics of Interest in Anesthesia, Apr. 25-26, Howard Johnson Motel, Pensacola Beach. For information: Warren W. Sears, M.D., 1717 N. "E" Street, Suite 205, Pensacola 32501.

MAY

Cardiology for the Primary Care Physician, May 7-9, Hyatt Regency, Sarasota. For information: Leonard S. Dreifus, M.D., Joel Morganroth, M.D., Lankenau Hospital, Philadelphia, PA 19151.

Seventh Annual Advances in Neonatal and Pediatric Respiratory Care, May 7-9, Sheraton Sand Key Hotel, Clearwater Beach. For information: Robert Cavanaugh, M.D., All Children's Hospital, 801 6th Street South, St. Petersburg 33701.

ECG Interpretation and Arrhythmia Management, May 8-10, Don Cesar Hotel, St. Petersburg. For information: Stephen E. Mattingly, 64 Inverness Drive, East, Englewood, Colorado 80112.

Human Sexuality, May 14-16, Gainesville Hilton, Gainesville. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Personality Adaptation Theory Used in Working With Couples and Families, May 22, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Fort Walton Beach 32548.

Master Approach to Cardiovascular Problems, May 29-31, The Contemporary Hotel, Walt Disney World, Lake Buena Vista. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

JUNE

Annual Homecoming Symposium (Psychiatry), June 12-13. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

6th Annual Suncoast Pediatric Conference, June 14-17, Sheraton Sand Key, Clearwater Beach. For information: Frank J. Cozzetto, M.D., c/o All Children's Hospital, Development Department, 801 6th Street South, St. Petersburg 33701.

FAFP 32nd Annual Scientific Assembly, June 17-21, Daytona Hilton, Daytona Beach. For information: Guy T. Selander, M.D., 1736 University Boulevard South, Jacksonville 32216.

13th Family Practice Review, June 22-26, The Breakers, Palm Beach. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Cardiac Ischemia and Arrhythmias: Current Concepts for Diagnosis and Treatment, June 26-28, Dutch Inn, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood, Colorado 80112.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, (7th Annual Review Course), Aug., Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

A peripheral vasodilator
for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®
Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

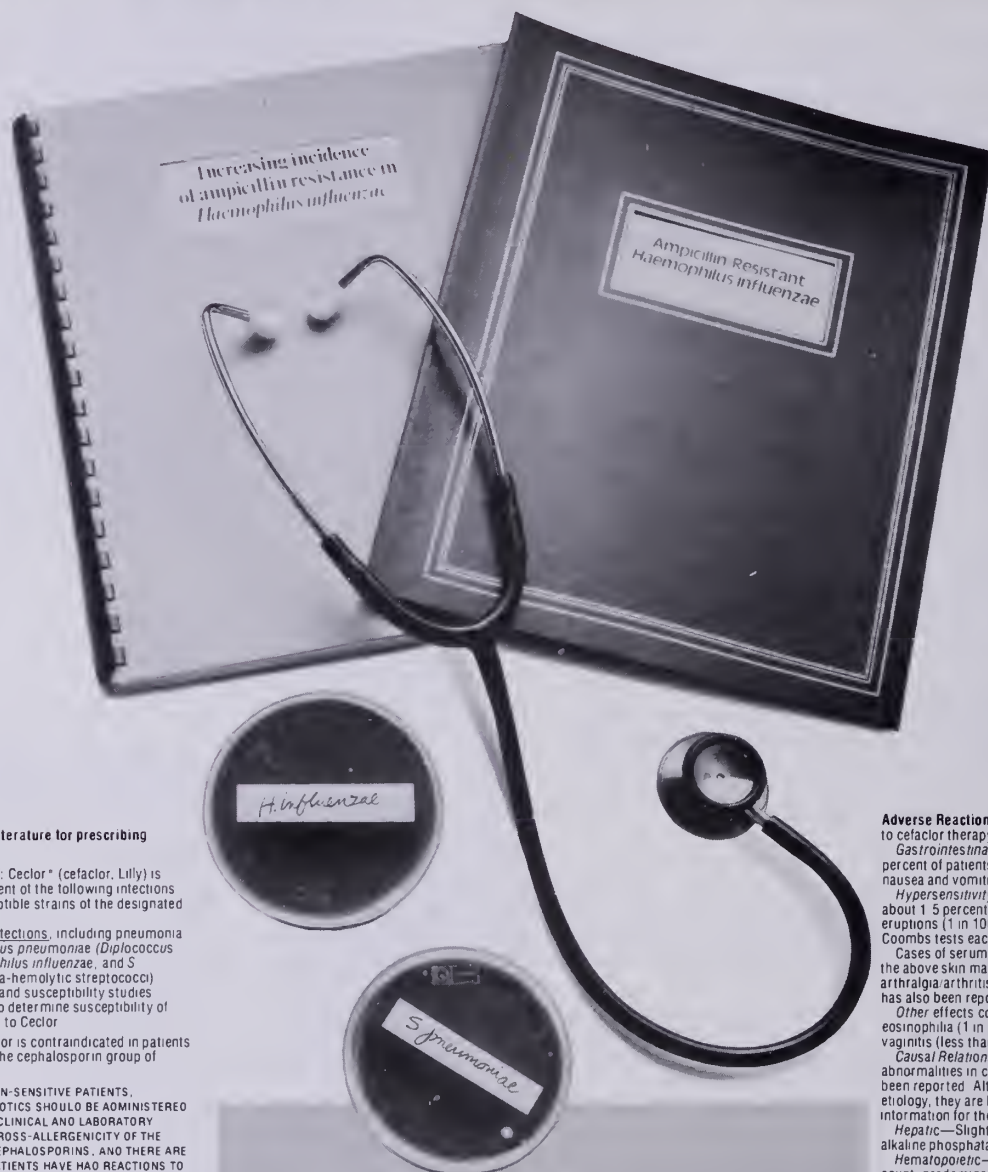
Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



An added complication... in the treatment of bacterial bronchitis*



Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage. Cefclor* (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established.

The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.
Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below: **Gastrointestinal** symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[103060R]

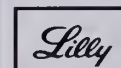
*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor* (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975
2. Antimicrob. Agents Chemother., 11:470, 1977
3. Antimicrob. Agents Chemother., 13:584, 1978
4. Antimicrob. Agents Chemother., 12:490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978
6. Antimicrob. Agents Chemother., 13:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285
Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630

100061

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

PRIMARY CARE and subspecialty physicians to join multispecialty group in South Palm Beach County. Excellent facilities. Compensation includes possibility of ownership in P.A. Send CV to Post Office Box 23606, Oakland Park, Florida 33334.

WANTED/ONCOLOGIST. Central Florida, Excellent Opportunity. Please send C.V. to C-1022, Post Office Box 2411, Jacksonville, Florida 32203.

DELRAY BEACH — No refraction or contact lens fitting. Prefer glaucoma specialist. Salary and terms negotiable. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

LOVELY SOUTHWESTERN CLIMATE — multispecialty group seeking OB-GYN physician. Substantial guarantee. Contact Talton Francis, El Paso Medical-Surgical Associates, P.A., 10301 Gateway West, El Paso, Texas 79925.

LOVELY SOUTHWESTERN CLIMATE — multispecialty group seeking anesthesiologist. Substantial guarantee. Contact Talton Francis, El Paso Medical-Surgical Associates, P.A., 10301 Gateway West, El Paso, Texas 79925.

MOORE HAVEN, Glades County (on Lake Okeechobee) — Immediate need

for Family Practitioner to live in Moore Haven; population 2,000; hospitals 25 and 45 miles away. Agricultural community with new industry moving in. Health department being only medical facility. Excellent fishing and hunting. Please contact: Walter C. McCants, RPH, P.O. Box 951, Moore Haven, Florida 33471. Phone (813) 946-1212. 9-5:30 p.m.

NORTHWEST FLORIDA — PSYCHIATRIST needed for part-time work with our out-patient program and 15-bed inpatient program (Crisis Stabilization Unit). Florida license (or eligibility) required. Private practice and consulting opportunity available. Excellent fringe benefits, great life style, salary competitive for area. Lovely semi-rural area just northeast of Pensacola. Send resume to Personnel Department, Santa Rosa Mental Health Facility, 400 Stewart Street, Milton, Florida 32570. Phone (904) 623-9434. Equal Opportunity Employer.

FLORIDA — Well established East Coast Group seeks fourth Pediatrician. Salary leading to early partnership. Send C.V. Reply C-1028, Post Office Box 2411, Jacksonville, Florida 32203.

GROWING 21-MAN multi-specialty group, with five family physicians, seeking a 6th, board eligible or board certified family physician. Located on the East coast of Florida. Competitive salary and benefits are available. Please send C.V. to C-Post Office Box 2411, Jacksonville, Florida 32203.

EMERGENCY CLINIC, ORLANDO, FLORIDA — Family practitioner or emergency physician for free-standing emergency clinic. No nights. No hospital responsibilities, new facilities. Send C.V. to William Meek, M.D., Minor Emergency Medical Clinic, Post Office Box 577, Winter Park, Florida 32789. Phone: (305) 277-0550.

EXCELLENT OPPORTUNITY to join well established practitioner in beautiful St. Augustine, Florida — initially to share suite and call, with later opportunity for partnership. Well equipped JCAH hospital. Contact Robert Wise, M.D., (904) 829-6591 or Suite 5, Flagler Hospital

Doctor's Building, St. Augustine, Florida 32084.

GENERAL INTERNIST wanted for growing, non-profit Community Health Center in West Palm Beach. Must be eligible to achieve hospital privileges. Full-time position; no overhead. Contact Byron S. Arbeit, Executive Director, Mid-County Medical Center, 8190 Okeechobee Blvd., West Palm Beach, Florida 33411. (305) 684-1119.

THE U. S. DEPARTMENT OF LABOR, Office of Worker's Compensation Programs, Jacksonville office, needs physician approximately 20 hours per week to review medical charts and provide medical opinions. Send CV to 400 West Bay Street, Box 35049, Jacksonville, Florida 32202, or call Ray Gerrald, (904) 791-3092.

INTERNIST / Board Certified or Board Eligible — Group of 15 Board Certified Internists, several subspecialty certified, seeks association with a Board Certified or Board Eligible Internist. Excellent academic stimulus; financial security with progressive incentive. No investment necessary. Beautiful area of Palm Beach, Florida. Please send curriculum vitae to Leonard W. Appleby, M.D., The Lake Worth Medical Center, 518 North Federal Highway, Lake Worth, Florida 33460.

PHYSICIAN WANTED to share office expenses with general practitioner. Reply C-1030, Post Office Box 2411, Jacksonville, Florida 32203.

WEST COAST FLORIDA: General Internist (with or without subspecialty). Rapidly growing multispecialty group. New facility, full ancillary services, adjacent ultra-modern hospital. Excellent remuneration and fringe benefits. Send C.V. to C-1031, Post Office Box 2411, Jacksonville, Florida 32203.

Situations Wanted

PULMONARY INTERNIST, ABIM, University trained all phases of pulmonary medicine, seeks practice position, available July 1981. Reply Clifford Benezra, M.D., 15911 Godwin Court, Fountain Valley, California 92708. (714) 775-0142.

UROLOGIST, 30, American graduate, Board eligible. Excellent training at large New York City Medical Center. Available July, 1981. Seeks group practice or partnership. Call (212) 876-5175.

GENERAL, COLON AND RECTUM SURGEON, trained in Colonoscopy, Board eligible, 35, seeks position in Florida to practice either one specialty or both. Speaks Spanish fluently. Available October 1981. Contact: Luis F. Espallat, M.D., 1517 Texas Avenue, Homestead AFB, Florida 33039. Phone (305) 257-2870.

LOCUM TENENS — COMP-HEALTH. Our medical group can place a well-qualified physician in your practice during your absence. For more information call or write: Comprehensive Health Systems, Inc., 175 West Second South, Salt Lake City, Utah 84101. (801) 532-1200.

UROLOGIST seeking position in group or multispecialty practice. Graduate of University of Miami School of Medicine in 1976. Urologic residency experience at U.S.P.H.S. Hospital, Columbia Presbyterian, and Memorial Sloan Kettering in New York City. All areas considered. Available Summer 1981. Curriculum Vitae available. Reply C-1032, Post Office Box 2411, Jacksonville, Florida 32203.

UROLOGIST, 31, Board Eligible, excellent training in Pediatric and adult Urology desires partnership, solo or group practice. Available July 1981. Reply C-1033, Post Office Box 2411, Jacksonville, Florida 32203.

INTERNIST — PULMONARY DISEASES SPECIALIST, Board Certified in both, desires association with multi-specialty group or hospital based practice. Write R. G. Cala, M.D., 7027 N. Hamlin, Lincolnwood, Illinois 60645.

COLORECTAL SURGEON to join group or partnership, available July 1981. Prefer Sarasota/St. Petersburg area. CV on request. Dennis A. Fried, M.D., Department of Colorectal Surgery, Cleveland Clinic.

BOARD CERTIFIED (Family Medicine) Florida license seeks 40 hour a week job in private clinics, public health, or Nursing Homes, also Locum Tenens. Reply: 333 N.E. Surrey Street, Port St. Lucie, Florida 33452. Telephone: (305) 878-8834.

WANTED-PEDIATRIC JOB opportunities anywhere in Florida. Have Florida License. FMG Contact: Dr. Dharmappa, 1700 Mary Court, Apt. 1, Alma, Michigan 48801. Phone (517) 463-2065.

INTERNIST-PULMONOLOGIST, 33, University Hospital trained in Bronchoscopy, I.C.U., P.F.T., Swan-Ganz. Wife physiatrist University trained. Seeking job or practice after July 1981. Reply C-1034, P. O. Box 2411, Jacksonville, Florida 32203.

JOHN L. DRISCOLL, M.D. — General Surgery Resident; CMDNJ/Board Eligible; holds current Florida Medical Licensure; seeking General Surgery practice, group or partnership; available July 1981. Reply: 631 Avenue E, Bayonne, New Jersey 07002.

32 YEAR OLD PEDIATRICIAN available April 1981. Solo or group practice. Small to medium size community. Write to C-1035, P. O. Box 2411, Jacksonville, Florida 32203.

Practices Available

DERMATOLOGY PRACTICE — for sale: fully equipped and furnished, old, well established in Miami. Very easy terms. Phone (305) 753-1293.

MIAMI — INTERNAL MEDICINE practice for sale. Active, near good hospital. Reply: M.D., Post Office Box 560812, Miami, Florida 33156.

MEDICAL OFFICE AVAILABLE APRIL 1981, 475 Biltmore Way, Coral Gables; 1,000 square feet. All furniture, fixtures and equipment ready for sale intact to lessee. Functional, tasteful office, "ready to go" for specialist or generalist or new physician. Call 443-8767 or 665-1713 after 5.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location; off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-

Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

DURANGO, COLORADO: Magnificent 35 to 40 acre Ranchsites on 2,000 acre ranch. Only a few left. From \$3,000 per acre. Will finance. Incredible hunting on property. Year 'round recreation, fabulous skiing. Russell Yates, Beaver Creek Ranch, P.O. Box 2433, Durango, Colorado 81301. Telephone (303) 259-2680.

ORLANDO: For rent, two offices 1,300 and 2,000 sq. feet in medical building with four other specialists at 6003 Silver Star Road. Excellent location, near Brookwood Hospital. Telephone (305) 295-4644.

VERO BEACH — SUBLET — 2,040 square feet office in professional building in excellent location. Custom decorated for Pediatrician tenant, suitable for other specialties, solo or partnership. Beautiful decor, excellent layout. Phone: (305) 567-2150, Dr. Jere Fitts.

Equipment

FOR SALE — Olympic Fiberoptic Bronchoscope, used two times. All attachments. Excellent condition. \$3,000 firm. Contact L. C. Taylor, M.D., 320 Parkview Place, Lakeland, Florida 33801. Phone (813) 682-4913.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Col, 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Twenty-Five Years Ago

In *The Journal of the Florida Medical Association* for February 1956:

FMA's first permanent home, at 735 Riverside Avenue in Jacksonville, will be ready for occupancy in mid-1956 . . . FMA Secretary-Treasurer **Samuel M. Day, M.D.**, addressed supervisors and drivers of the Jacksonville Coach Co., on "Quacks in Medicine" . . . About 75 physicians attended the Bay County Medical Society's First Annual Scientific Dinner Meeting . . . **James N. Patterson, M.D.**, of Tampa, assumed office as President of the Hillsborough County Medical Association . . .

And so it was in *Florida Medicine* 25 years ago this month. — EDH

When
impotence
is due to androgenic deficiency.

Android 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg mg mg

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-pubertal cryptorchidism.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250, Rx only.

Write for new double blind study reprints and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Advertisers

Anderson-Clayton Foods New Age Sandwich Slices	80	Merrell-National Bentyl	132-4
Bristol Laboratories Tegopen	96	Mount Sinai Meetings	79, 92
Boots Pharmaceutical F-E-P, Twin-K, Su-Ton	94a	Pennwalt Pharmaceuticals Zaroxolyn	90-92
Brown Pharmaceuticals Cerebro-Nicin	136	Purepac Pharmaceuticals Generic Drugs	127
Lipo-Nicin	137	Roche Laboratories Librax	126a
Android	141	Valium	78
Burroughs Wellcome Zyloprim	82	Bactrim	143-4
Neosporin	94a	Institutional	89
Convention Press Service	98, 134	Limbitrol	94a
Eskofot America Personal copier	121	Southeast Banks Service	84
Florida National Banks Service	92	University of Miami Meetings	90, 117, 130
Geriatric Pharmaceutical Co. Cevi-Bid	122	Wetzel Service	118
Menic	95	Willingway Hospital Service	88
Janssen Pharmaceuticals Vermox	116-7	Wyeth Laboratories Cyclapen	86-7
Eli Lilly & Company Ceclor	138		

Florida Medical Association Officers and Council Chairmen

Officers

T. Byron Thames, M.D., Orlando, President
 Sanford A. Mullen, M.D., Jacksonville, President-Elect
 Gerold L. Schiebler, M.D., Gainesville, Vice President
 Robert E. Windom, M.D., Sarasota, Secretary
 J. Russell Forlaw, M.D., Boynton Beach, Treasurer
 Richard S. Hodes, M.D., Tampa, Immediate Past-President
 James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
 Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
 W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
 Louis C. Murray, M.D., Orlando, Legislation and Regulations
 William W. Thompson, M.D., Ft. Walton Beach, Health Care Financing
 Joseph T. Ostroski, M.D., Miami, Medical Services
 Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
 Dick L. Van Eldik, M.D., Lake Worth, Specialty Medicine



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

MAR 24 1981

Charmeco

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases “overmedicated society,” “overuse,” “misuse,” and “abuse,” my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you’ve made. Recall how often you’ve heard, as a result, “Doctor, I don’t know what I would have done without your help.”

You and I can feel proud of what we’ve done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you’ll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/Roche)® , please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.



North Ridge General Hospital

PRESENTS
THE FIFTH ANNUAL

Cardiovascular Symposium

"FRONTIERS IN CLINICAL CARDIOLOGY"

March 9 - 12, 1981

A distinguished faculty has been assembled for this Symposium which will be of value to all physicians involved in the care of patients with cardiac disease. The program will focus on reappraising the art of bedside clinical cardiology.

Guest Faculty:

AGUSTIN CASTELLANOS, M.D., F.A.C.C.

Professor of Medicine
Director, Clinical Electrophysiology
University of Miami, School of Medicine
Miami, Florida

JAMES L. COX, M.D., F.A.C.C.

Department of Surgery
Duke University Medical Center
Durham, North Carolina

J. MICHAEL CRILEY, M.D., F.A.C.C.

Professor Medicine & Radiological Sciences
UCLA School of Medicine
Chief, Division of Cardiology
Harbor UCLA Medical Center

**JOHN F. GOODWIN, M.D., F.R.C.P. (LOND.)
F.A.C.C.**

Professor of Clinical Cardiology
Royal Postgraduate Medical School
London, England
President, European Cardiac Society

HENRY J. L. MARRIOTT, M.D., F.A.C.C.

Director, Clinical Research
The Rogers Heart Foundation-St. Petersburg, Fla.
Clinical Professor of Medicine (Cardiology)
Emory University, Atlanta

PROCTOR HARVEY, M.D., F.A.C.C.

Professor of Clinical Cardiology
Georgetown University Medical School
Washington, D.C.

Program Chairman:

Ali R. Ghahramani, M.D., F.A.C.C.

Registration: \$150 (includes dinner and breaks)
Course Credit: 22 C.M.E. Hours
Program scheduled for afternoons and evenings.

REGISTRATION IS LIMITED

FOR FURTHER INFORMATION CONTACT: Barbara Chandler, North Ridge
General Hospital 5757 N. Dixie Hwy., Ft. Lauderdale • (305) 776-6000



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

MARCH 1981 • VOL 68 • NO. 3 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.
E. Charlton Prather, M.D.

Assistant Editors

James K. Conn, M.D.
Lee A. Fischer, M.D.
Edward Pedrero Jr., M.D.
J. Lee Dockery, M.D.
(from Board of Governors)

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Susan L. Milhoan

Consulting Editorial Staff

William A. Alonso, M.D.	Rublin Klein, M.D.
Fuad S. Ashkar, M.D.	Karl J. Kramer, M.D.
Hubert A. Aronson, M.D.	R. G. Lacsamana, M.D.
Thomas D. Bartley, M.D.	Richard F. Lockey, M.D.
Robert L. Batey, M.D.	Philander D. Morgan, M.D.
Pierre J. Bouis Jr., M.D.	George Morris, M.D.
Ms. Deborah B. Wilbur	George A. Neder Jr., M.D.
William T. Branch, M.D.	Richard S. Panush, M.D.
Miguel A. Brito, Jr.	R. A. Penalver, M.D.
Manuel L. Carbonell, M.D.	John K. Petrakis, M.D.
Ronald W. Case, M.D.	Phillip B. Phillips, M.D.
Louis E. Cimino, M.D.	Michael R. Redmond, M.D.
Charles Craig, M.D.	Albert L. Rhoton, M.D.
R. Jay Cummings Jr., M.D.	James F. Richards Jr., M.D.
Raul deVelasco, M.D.	Arvey I. Rogers, M.D.
James E. Deming	Lees M. Schadel, M.D.
Pablo Enriquez, M.D.	Frederick W. Schert, M.D.
Richard A. Essman, M.D.	Guy T. Selander, M.D.
Franklin J. Evans, M.D.	Roberto A. Sosa, M.D.
Robert F. Feltman, M.D.	John Stone, M.D.
Richard Feinstein, M.D.	Robert H. Threlkel, M.D.
Lawrence M. Fishman, M.D.	Benjamin E. Victorica, M.D.
John W. Glotfelty, M.D.	Norman H. Wasserman, M.D.
Allan L. Goldman, M.D.	Thomas M. Wiley, M.D.
Henry L. Harrell, M.D.	Charles D. Williams, M.D.
Allan Herskowitz, M.D.	Governor M. Witt, M.D.
James T. Howell, M.D.	Frederic C. Wurtzel, M.D.
Troy H. Hutchinson, M.D.	

Subscription Rate: \$15.00 per year, single copy. \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

Special Auxiliary Issue

This issue of *The Journal of the Florida Medical Association* was compiled by members of the FMA Auxiliary, and is devoted to the projects and interests of Auxiliary members. We are most grateful to the authors and contributors to this issue of *The Journal*. (See contents on opposite page).

Editorial

- 153 Hats Off to the Auxiliary
Daniel B. Nunn, M.D.
- 153 The FMA/FMF Impaired Physician Program
Joseph G. Matthews, M.D.

Organization

- 205 Gov. Bob Graham Praises FMA Promotion Of Public Health Programs
- 209 Medical Malpractice Prevention Seminars Offered by Physicians' Reciprocal
- 210 Pfizer Dialogue Programs to Carry Out Annual Meeting Stress Theme
- 214 Impaired Physician Intervention Workshop in Miami This Month
- 215 FMA Annual Meeting Program to Schedule Basic Life Support Certification

Departments

- 151 President's Page
Remembering Those Who Serve
T. Byron Thames, M.D.
- 159 Professional Liability Update
- 204 Medical News Around the State
- 222 Meetings
- 231 Classified Advertising
- 234 Index to Advertisers
- 234 FMA Officers and Council Chairmen

Cover

See page 165.

Special Issue

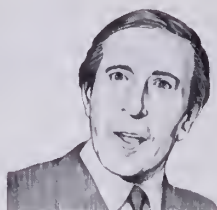
FMA Auxiliary

Auxiliary in Action	
Mrs. Fred P. (Anne) Swing	163
The FMA Auxiliary — A Half Century of Progress and Accomplishment	
Mrs. C.H. (Marion) Gilliland	166
Action in the Counties	
Mrs. L.G. (Mae) White	169
The Auxiliary's Talent Search Program	
Mrs. Thomas (Laurie) Busard	177
Highlights from The Auxiliary Beeper	
Mrs. Rod M. (Lita) Martija	179
Join the PR Team	
Mrs. Angus W. (Wylene) Graham	186
Legislation	
Mrs. James G. (Beebe) White	188
How the AMAA Pumps Life Into State and County Auxiliaries	
Mrs. Daniel B. (Gloria) Nunn	190
Till Death Do Us Part	
Mrs. F. Norman (Elizabeth) Vickers	192
The Florida Physician and His Family in Crisis	
Mrs. Frederick J. (Marybeth) Weigand	195
Come to the Annual Meeting and Bring Your Spouse	
Mrs. Milton (Jo) Tignor	200
In the Wings . . .	
Mrs. Francis C. (Ruth) Coleman	202

FROM DIETARY COMPLAINTS



"Too Bland"



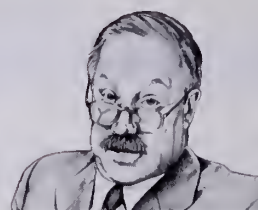
"Tasteless"



"No Variety"



"Hard To Cook"



"Only
Cottage Cheese?"



"Daddy's
Dull Diet"

TO COMPLIANCE

INTRODUCING *New Age*TM SANDWICH SLICES

- 90% less cholesterol
- 75% less saturated fat

Now, New Age—a cheese substitute made with vegetable oil—provides the good taste of process cheese without its restrictively high cholesterol content.

New Age has 90% less cholesterol, 75% less saturated fat, yet provides all the protein, vitamins and minerals of process cheese... good news for all health-conscious patients!

AMERICAN
SWISS
SMOKEY
HOT PEPPER



*New Age*TM

is consistent with
the cholesterol-control,
low-fat recommendations
of the third edition of
**The American
Heart Association
Cookbook.**



President's Page

Remembering Those Who Serve

This issue of *The Journal* pays special tribute to the Auxiliary to the Florida Medical Association. You and I recognize them as the special people who contribute so much to our personal lives. They create the home environment to which we retreat daily to forget the stresses of our profession. They provide for us the love and affection which we hope to project in all our relationships with others.

In many cases they contribute the major portion of rearing our children and shaping their study habits and providing their most available source of consolation against the trials of their world. Often they are the ones who keep us dressed well and keep our homes clean. They do the thousands of jobs we can't find the time for — like banking, grocery shopping, getting the car inspected, etc. Frequently they sublimate their own priorities and their own occupations and their own avocations for our own. And, mostly, they do it with a smile or without our ever realizing they are doing it for us.

Spouses the world over do these things and many others for the ones they love. Our spouses do all these things and many more for each of us. Through their organization into the Auxiliary to the Florida Medical Association they have become an active partner with us in the many aspects of our professional life. They do for us in our professional life much like what they do in our private life.

They have provided needed funds for education and

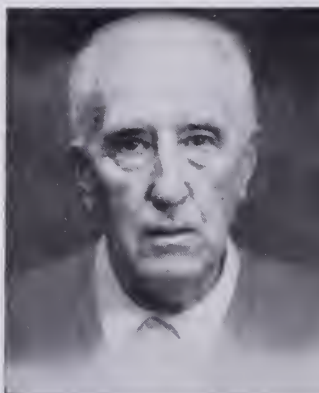
research through multiple projects including their cookbook. They have actively assisted us in the planning and financing of our new Impaired Physician Program including the planning of the very successful Impaired Physician Workshop at the Leadership Conference in Orlando at the end of January.

They have been the very heart of our successful legislative program. We may determine the policies and legislative goals and our talented staff and lobbyists pursue them diligently but our real success has come because our Auxiliary has made the personal contacts with legislators, patients and concerned parties. They organize the letters and calls and telegrams which have made our legislative desires into realities.

In the six years I have served on the Board of Governors and the two as President-Elect and now as President, we have never asked them to do something which they have not done willingly and successfully. Indeed, they have pinpointed and initiated many of our programs.

We are all too often guilty of failing to praise those who do the most for us in our personal as well as professional lives. This message is being written before Valentine's Day and will appear after Valentine's Day. Let us each individually and collectively take the time to say how proud we are to share our lives and our professions with those we love — our spouses, our families and our Auxiliary. They deserve a special Valentine each and every day!

T. Byron Shuman M.D.



Dual-action therapy to enhance mental and physical activity in the elderly.

MENICTM

PENTYLENETETRAZOL 100 mg • NICOTINIC ACID 50 mg

Menic combines the proven effectiveness of cortical stimulation and cerebral vasodilation, reducing mental confusion, faulty memory and negative social behavior often associated with the senility syndrome.

DOSAGE: Two tablets after each meal.

SIDE EFFECTS: Occasionally flushing and pruritus associated with niacin administration.

PRECAUTIONS: Use with caution in patients with low convulsive threshold, focal brain lesions, severely impaired liver function,

peptic ulcer, diabetes, and gall bladder or liver diseases. Niacin may potentiate hypotensive drugs, phenothiazine derivatives and inactivate fibrinolysin.

CONTRAINDICATIONS: There are no known contraindications to Menic.



GERIATRIC PHARMACEUTICAL CORP. 397 JERICO TURNPIKE, FLORAL PARK, N.Y. 11001
PIONEERS IN GERIATRIC RESEARCH . . . DEVELOPERS AND SUPPLIERS OF CEVI-BID • GAYSAL • ISO-BID

Twenty Five Years Ago

In *The Journal of the Florida Medical Association* for March 1956:

New members of FMA included **David J. Lehman, M.D.**, of Hollywood, later to become a member of the Florida House of Representatives . . . **J. M. Ingram Jr., M.D.**, of Tampa, spoke on "Socialized Medicine" at a meeting of the Tampa Chapter of the Daughters of the American Revolution . . . **Rufus K. Broadaway, M.D.**, of Miami, now a Florida Delegate to the American Medical Association, was licensed to practice in Florida . . .

And so it was in Florida medicine 25 years ago this month. — E.D.H.

Hats Off to the Auxiliary

The 1981 Auxiliary issue of *The Journal of the Florida Medical Association* is an accomplishment of which both the FMA and FMAA should feel justly proud. This jointly supported issue provides an excellent overview of current Auxiliary interests and activities. Special credit is due Mrs. Fred P. (Anne) Swing, President of the FMAA, who selected topics and wrote the lead article; those Auxilians who responded to the call and contributed the other papers; and the artistic member of the

group whose creative talents supplied an outstanding cover. It is noteworthy and quite commendable that all contributors worked assiduously within an abbreviated time schedule during the Christmas and New Year holiday season. On behalf of the entire *Journal* staff, the Editor wishes to express appreciation and felicitation to the FMAA for another job well done.

Daniel B. Nunn, M.D.
Editor

The FMA/FMF Impaired Physician Program

The individual generally regards his doctor as being ethical, honest, intelligent and trustworthy. It usually comes as a jolt when one learns that his own trusted family doctor has become a "drunk", a "hophead", or a "dope addict". Frustration, consternation, and disillusionment follow and the usual reaction is to simply *change doctors*.

When physicians occasionally observe a colleague at social functions apparently under the influence of alcohol or perhaps drugs they tend to subconsciously excuse his behavior and silently hope that he will not be treating his patients while under the influence. This is, of course, wishful thinking! It is also common for colleagues to ignore or avoid him and join the "conspiracy of silence".

This cold, thoughtless technique of handling a colleague in trouble, traditionally fails and if anything, it accelerates his downward spiral to eventual oblivion. We in the profession do have a moral obligation to step in and help. There are several very clear reasons why this must be done.

First, the patients' welfare must be protected; they must not be exposed to possible risk due to inaccurate prescribing by an impaired physician. Secondly, the doc-

tor, his practice and his life should be salvaged. And thirdly, the medical profession should be spared the ugly blemish.

Historically, medical associations and hospital staffs have used many approaches and techniques to handle sick colleagues. Close friends have been assigned to approach the doctor and persuade him to mend his ways. Ad hoc committees have been formed and given similar assignments. Hospital staffs and boards have restricted or suspended hospital privileges. Clergymen have been called in. State regulatory agencies have been used to restrain the physician from practicing his profession, by lifting his license! IDAA (International Doctors in Alcoholics Anonymous) is an organization that has been in existence for many years and when used, has resulted in a rather impressively high success rate.

In the past few years special programs have evolved for the purpose of helping the physician in need as well as protecting the public. It is now known that this approach appears the most successful of all. The FMA House of Delegates and the FMA Auxiliary after indepth study have mandated that such a program be set up in

Florida. It has been done elsewhere, it will be done here, and it will succeed!

The program when fully implemented will be similar, but not necessarily identical to the program in our neighboring state of Georgia. It will not be a *treatment* program but will be one which will have the capability of guiding the physician into a structured treatment and rehabilitation program available at various centers within the State or in the southeast.

There will be several features. There is a system to receive and confirm or validate reports that a physician may be in trouble. Confrontation teams will be established and trained for the purpose of approaching the doctor in need. These teams will offer support and encouragement and will serve as advocates not adversaries.

Education will also be an important function. The target audiences for this educational effort will be varied: physicians' families, medical students, medical associa-

tions, paramedical personnel and even the public. There are many physicians in the state who have already returned to private practice after having been successfully rehabilitated through other programs. These physicians usually refer to themselves as "*recovering or recovered* alcoholics (or addicts)". They are usually anxious and willing to involve themselves in these programs. Experience has shown that they can play very valuable roles. Their help will be solicited, used and appreciated.

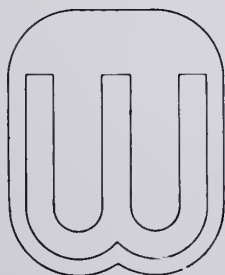
The existence of this program will be publicized, but it is obvious to all that the names and records of those under treatment will have to be held in the strictest confidence. They must be shielded from the prying eyes of the unscrupulous press. If confidentiality is not assured the program is surely destined to fail.

Joseph G. Matthews, M.D.
Orlando





**REINSURANCE
BROKERS for
Florida Physicians
Insurance Reciprocal
—serving physicians
throughout Florida**



**The
Wetzel
Company,
Inc.**



Tail of whipworm
(*Trichuris trichiura*)

Vermox[®]: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX [®]	68%*	93%**
Mintezol ¹	35%†	45%††
Antiminth ²	Not Indicated	
Povan ³	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX[®].

Please see following page for Summary of Prescribing Information.

**Broad-spectrum coverage
in mixed helminthic infections**

Vermox[®] TABLETS
(mebendazole)



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

©Janssen Pharmaceutica Inc. 1980

JPI-023



**Broad-spectrum
coverage in mixed
helminthic infections**

Vermox[®]
(mebendazole)
TABLETS

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX[®] in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX[®] in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

*Committed to research...
because so much remains to be done.*

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

MASTER APPROACH TO CARDIOVASCULAR PROBLEMS

Ninth Annual Conference

At

**The Contemporary Hotel
Walt Disney World Resort Complex**

Orlando, Florida

May 29 - 31, 1981

Guest Speakers:

Robert S. Eliot, M.D.
Mark E. Josephson, M.D.
Dennis Krikler, M.D.

University of Miami Faculty:

Agustin Castellanos, M.D.,
Bernard Fogel, M.D.,
Louis Lemberg, M.D., and
Robert J. Myerburg, M.D.

(For more information please call (305) 325-6411 or complete coupon and mail to: Y. Barcena, Cardiology (D-39), University of Miami School of Medicine, P. O. Box 016960, Miami, Florida 33101).

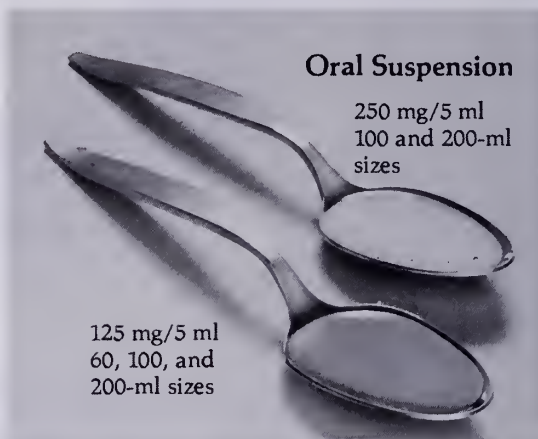
Please send me more information regarding
"MASTER APPROACH TO CV PROBLEMS"

Name _____

Phone () _____

Address _____

easy to take



Keflex®
cephalexin

Additional information available
to the profession on request.



Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630



Professional Liability Legal Update

Medical Malpractice Claims Causes and Prevention

James W. Walker, M.D.

Previously, we have reported in *The Journal of the Florida Medical Association* the 10 leading causes of medical malpractice claims which had been reported for the FMA's sponsored plans for the years 1963 through 1979. This report updates the data through December 31, 1980.

Our series of closed claims in Florida is now 10,324 which represents losses paid in excess of \$143 million. The claims have been divided into 21 categories and the 10 most frequent as to frequency and severity are shown below:

Ten Leading Malpractice Causes (FMA's Sponsored Plans 1963 - 1980)

Frequency

1. Improper diagnosis (not involving surgery)
2. Technical surgical error
3. Adverse reactions to drugs
4. Improper treatment of fractures
5. Improper anesthesiology
6. Foreign body left in patient during surgery
7. Injury to child in childbirth
8. Injury from falls (during examination or while under doctor's care)
9. Infection in surgical site
10. Employee error

The Author

JAMES W. WALKER, M.D.

Dr. Walker is President of the Professional Insurance Management Company (PIMCO) in Jacksonville.

Severity

1. Injury to mother in childbirth
2. Improper anesthesiology
3. Injury to child in childbirth
4. Improper diagnosis (not involving surgery)
5. Technical surgical error
6. Adverse reactions to drugs
7. Infection in surgical site
8. Employee error
9. Assault (generally, operating without prior permission)
10. Foreign body left in patient during surgery.

Frequency

There have been minor changes in the classifications as to frequency. Injury to a child in childbirth has increased from No. 8 to No. 7. This is significant in that injury to a child in childbirth ranks No. 3 as to the severity of claims paid.

Severity

The trend as reported for the past two years as to awards in cases resulting from injury to a mother in childbirth has continued. It continues to rank No. 1 as to the severity of the claims received. Improper anesthesiology continues to be ranked No. 2 and an injury to a child in childbirth continues to be ranked No. 3. Three years ago, these three did not appear in the top 10 as to severity. Significant changes also in severity of claims is that improper diagnosis (not involving surgery) has risen from fifth place to fourth. Adverse reaction to drugs is now in sixth place. Error of an employee which is No. 10 in fre-

quency did not appear in the top 10 as to severity until this year. Foreign bodies left in patients during surgery which is No. 6 in frequency now appears in the top 10 as to severity.

Comment

These changes are monitored closely to determine changes in the medical malpractice picture in Florida. It is obvious from review of the rank order of these claims that most are preventable.

There continues to be a need for obstetricians,

anesthesiologists, and pediatricians to document thoroughly those procedures in which they become involved.

Armed with this data, most of which has been subclassified, the Professional Insurance Management Company on behalf of the Florida Physicians' Insurance Reciprocal will launch an ambitious medical malpractice prevention program throughout Florida during 1981. The premiums each of us must pay for professional liability insurance will ultimately be determined by how successful we are in claims prevention.

GIARDIASIS.

NOW THERE IS A BETTER METHOD OF DIAGNOSIS WHEN STOOL EXAMS ARE NEGATIVE.

ENTERO-TEST® A 140cm nylon line coiled inside of a gelatin capsule designed to retrieve duodenal contents without intubation. Easily administered and tolerated. ENTERO-TEST® has the following advantages:

- A viable alternative to intubation
- Well tolerated by all age groups
- Pediatric sizes available
- Useful in the diagnosis of bleeding and a variety of intestinal parasites

Rosenthal and Leibman studied 23 pediatric patients with diarrhea. All had one or more negative stools. Of these, 5 patients had *Giardia lamblia*

which was diagnosed by the simple ENTERO-TEST® procedure. Lopez and co-workers diagnosed Giardiasis in 22 patients with the ENTERO-TEST® compared to 4 patients by stool exams. ENTERO-TEST® has proved to be a useful and effective method for the localization of upper GI bleeding, and the diagnosis of Typhoid carriers, strongyloidiasis and other parasitic diseases.

References:

- Rosenthal, P., and Liebman, W.M.: Comparative study of stool examinations, duodenal aspiration, and pediatric Entero-Test for giardiasis in children. *J. PEDIAT.* 96: 278 (Feb.) 1980.
- Thomas, G. E., et al: Use of the Entero-Test duodenal capsule in the diagnosis of giardiasis. *South Afr. Med J.* 48: 2219, 1974.
- Lopez, M. E., et al: Infeccion duodeno-yeyunal en el niño con desnutricion energetico-proteínica. *Rev. Med. Hosp. Nat. Niños* 13: 53, 1978.
- Gilman, R. H: Identification of gall typhoid carriers by a string bladder device. *The Lancet*: April 14, p. 795, 1979.



ENTERO-TEST®, The Solution. Simple And Convenient.



(800) 227-8162
2551 Casey Ave.
Mountain View
California 94043



PROFIT FROM OUR EXPERIENCE


For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

We specialize in attaining the results that you require from your account in the areas of:

- **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.
- **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.
- **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

PEOPLE WHO KNOW HOW.



Florida National Trust Services

214 Hogan Street
Jacksonville, Florida 32231
Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC

MICROSURGERY COURSES

The Microsurgery Laboratory at the University of Florida offers three and five day courses aimed at teaching techniques applicable to:

Extracranial to Intracranial Bypass
Digital Reimplantation
Tubal Reanastomosis
Vasovasostomy
Transsphenoidal Surgery
Temporal Bone Dissection
Other Microsurgical Operations

For Information write:

Mrs. Cindy Brady
Microsurgery Laboratory
Box J265
University of Florida Health Center
Gainesville, FL 32610

Summer Cruise/Conferences on Legal-Medical Issues



APPROVED FOR
23 CME CREDITS
CATEGORY I

By the American College of Legal Medicine
Seminars Directed by Irwin N. Perr, M.D., J.D.
Professor, Rutgers Medical School

Caribbean Conference — July 29 — August 8, 1981 aboard TSS Fairwind.* Visit St. Maarten, Antigua, Barbados, Martinique and St. Thomas.

Mediterranean Conference — August 22 — September 5, 1981 aboard Mts. Danae.* Visit major cities in Italy, Greece, Egypt, Israel, Turkey, Yugoslavia.

- All meals on cruise and aloft.
- Excellent Fly/Cruise group rates.
- Seminars conducted at sea.
- Hotel Danieli — Venice, Italy
- Alitalia scheduled flights to Italy.
- All transfers

The number of participants in each Conference is limited.
Early registration is advised.

For color brochure
and additional
information contact:

International Conferences
189 Lodge Avenue
Huntington Station, N.Y. 11746
Phone (516) 549-0869

Both conferences are designed to conform with the 1976 Tax Reform Act.

*Liberian Registry
**Greek Registry

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

MARCH 1981
VOL 68 • NO. 3

Auxiliary in Action

Mrs. Fred P. (Anne) Swing

"Get Into The Act" is the Auxiliary theme throughout Florida. Action is our business. We realize that no organization can remain exactly the same. Any group content to retain the "status quo" is deluded and headed for deterioration. You either regress or progress. Auxiliary prefers the latter alternative. Our existence can be justified only by enthusiastic, active commitment to our goals. We are highly motivated to uphold the Florida Medical Association, respect its principles, and help promote its interests and programs. Auxiliary is firmly dedicated to community service and the continued improvement of health standards in our country.

You could liken Auxiliary to a giant beehive minus the queen and drones. Everyone is a worker of one type or another. Each county unit is buzzing with activity. Auxilians are encouraged to participate in tasks best suited to their particular personality and expertise. There is a specific place and a definite job for everyone. In fact, there is so much work to be done that there is never enough time or person-power to accomplish everything to our satisfaction. The answer is to persevere one day at a time and give each undertaking our best effort. Results are gratifying. The

Florida Medical Association Auxiliary is an upward mobile organization, continually struggling to be relevant, meeting challenges with up-to-date approaches. Otherwise we would lose our members to more perceptive groups. Florida's membership has increased steadily over the years. We are now the third largest auxiliary in the nation.

The key to progress and relevancy is enthusiasm. It is the fuel which keeps the Auxiliary machine running. Enthusiasm does not just happen. It is a precious commodity to be encouraged, stimulated, nurtured, and rewarded. Enthusiasm is contagious and as it spreads from member to member, the group is strengthened. Cooperation increases, making work easier and more pleasant. The impossible becomes possible.

Members are encouraged to feel enthusiastic about Auxiliary by first being helped to appreciate their own intrinsic value. A positive self-image transforms a humdrum individual into a personality. People who feel happy about themselves are more effective in relating to others.

Auxiliary stimulates enthusiasm for its projects by trying new ways of operation and being open to suggestion. Well developed long range plans allow for flexibility. There is a constant search for newer and better means of increasing efficiency. We are open to constructive criticism and advice. Any organization whose policies are set in concrete is destined to sink in the tide waters of changing times. Auxiliary is determined to stay afloat and go "full steam ahead"! To

The Author

MRS. FRED P. (ANNE) SWING

Mrs. Swing is President of the FMA Auxiliary, and resides in Charlotte Harbor.

accomplish this, counties are advised to adapt programs to their particular community needs, using creativity and imagination in attacking problems from their own frame of reference. Each county and branch, working in its unique manner, with common goals as guidelines, guarantees statewide involvement and action.

The enthusiasm of individual members is nurtured and developed by urging them to express opinions and preferences, giving direct input to the planning and implementation of Auxiliary projects. Each suggestion is treated with respectful consideration, whether or not it can be adopted. This is one of the best ways to make members feel free and eager to participate. The more a person enters directly into Auxiliary activity, the more enthusiastic and effective she becomes. This individual is an integral part of the group.

Enthusiasm is its own best reward, creating an exhilarating sense of purpose which gives the most mundane tasks proper importance in the overall scheme of things. It puts a spring in the step, a sparkle in the eye, and eager anticipation in the heart. Enthusiastic members are the backbone of Auxiliary. They make for maximum action with a minimum of complications.

The old axiom, "If you want a job well done, ask a busy person", is exemplified in Auxiliary. Our members are among the busiest people in our society. The average doctor's wife is quite different from the popular stereotype. She puts her family first, does most or all of her own housework, cares for several children, and is active in community and church. In many instances she is employed full or part time in business or the professions. Yet she finds time to be actively involved in Auxiliary work. Why? Because she realizes its importance.

Auxiliary action is not accomplished without some difficulty. There are prejudices to be overcome and wrong impressions to be corrected. At times our members have to be strong to persevere. Many people, including some physicians and physicians' spouses, fail to realize the importance of Auxiliary as a vital force in the promotion of a healthier nation. Our role is education, political action, and community involvement. There is little time for frivolous society activity. Of course, we must get to know one another and be supportive in times of stress and crisis. We are friends in the true sense of the word. How much productive activity can you accomplish with a perfect stranger?

Several recent movies and books have characterized the doctor's spouse as a self-indulgent individual

spending most of her waking hours in aimless pursuit of entertainment at the bridge table or country club. She is depicted in designer tennis outfits, over-priced afternoon dresses, velvet jeans, too much expensive jewelry, and a mink coat to wear for afternoons of leisurely shopping at exclusive boutiques. Her transportation from one luxurious spot to another is the flashiest sports car available.

These images are far from accurate. The typical doctor's wife has to budget her time and money the same as every other homemaker. She dresses appropriately for whatever activity she is undertaking. Most of her shopping time is spent in the supermarket. She lugs the groceries home in a car that is fuel efficient, but large enough to accommodate several children (hers and the neighbors') because she is almost inevitably in a car pool. If she is smart, the lady spends a certain amount of time in a planned exercise routine including a favorite sport and fitness program. This is essential to maintain the health necessary to carry out the rest of her strenuous schedule. Medical moms are great fans at swim meets, Little League, Pop Warner, school sports competitions, and any other functions involving their children. Auxiliary encourages its members to be the very best wives and mothers they can. We know this is our first priority.

An important aspect of being a good doctor's wife is learning to be patient and understanding when a demanding schedule keeps her spouse away from the family for long or frequent periods of time. The day the M.D.'s wife learns to accept upset plans and warmed over meals with a sincere smile and calm disposition, is the day she becomes a happier woman and her husband a happier man. Incidentally the children benefit as well. Mother's attitude colors their feelings. They can learn to be appreciative of times spent with Dad and not to complain when a fishing trip is upstaged by a hot appendix. Auxiliary, through seminars and discussions, attempts to promote this kind of understanding and acceptance. This is a part of Auxiliary action the public never sees, but from which they definitely benefit. A happy man can better concentrate on his profession, be it business, education, or medicine.

Auxiliary goes about its action in an orderly, dignified manner. We don't carry placards or march in demonstrations. We don't force our opinions on others. This does not diminish the depth of fervor we feel for the issues and problems we address. If you want to see auxiliarians in action, here are a few hints. Stop by the school playground and watch two or three enthusiastic young matrons in blue jeans, down on their hands and knees, painting an Immunization Re-

minder hopscotch on the blacktop. Then, go to the neighborhood community center and notice the ladies assisting in a health screening program. Drop into a local home for the aged and say "Hi" to the smiling woman visiting patients with no families. Wander on down to the supermarket and get in line behind the pretty young mother with two toddlers in tow. See her checking out an extra basket of canned foods to deliver to Family Services. Open the door at the high school auditorium and observe two energetic auxiliaries conducting a seminar on Breast Self Examination. Ring the doorbell at 211 Main Street and have a cup of coffee with the candidates at an Auxiliary Legislative Luncheon. Go to the Mental Health Center and observe three older ladies teaching macrame to teenage drug victims. Walk into the church social center and listen in on an Auxiliary sponsored Parenting Seminar. If you are not registered to vote, there

may be an auxiliary at your next county meeting authorized to register you on the spot. Do you see the young lady carrying a stack of folders into the high school principal's office? Those pamphlets are titled "Beyond Education." They are printed and distributed by Auxiliary to all public school teachers in an effort to combat Child Abuse. If you have a day to spend, attend the nearest Worry Clinic sponsored by your local Auxiliary. There will be auxiliaries everywhere - at the registration desk, serving lunch, attending lectures, and perhaps conducting a session or two.

Auxiliary is truly in action!!! There is not enough time to do everything today, but we look forward eagerly to each tomorrow.

- Mrs. Swing, 911 Harbor View Road, Charlotte Harbor 33950.

About the Cover

The cover for this Special Issue on the Florida Medical Association Auxiliary was created by Mrs. Dale R. (Toni) Charneco of Orange Park. Mrs. Charneco, a member of the Auxiliary and a talented painter, was contacted by Auxiliary President Mrs. Fred P. (Anne) Swing and asked to create a cover which would reflect the theme "Auxiliary in Action".

This task was artfully accomplished by Mrs. Charneco in the pastel-rendered abstract she explains thusly: "The circular bands of color represent our state

of Florida — blues for the beautiful rivers and beaches, yellow for our wonderful sunshine, and green for the magnificent trees."

The Auxiliary emblem in the center of the swirling bands is symbolic of the Auxiliary as an integral part and positive contributor to the accomplishments of organized medicine.

The abstract shapes represent the constant motion of the Auxiliary in support of FMA.

The FMA Auxiliary - A Half Century of Progress and Accomplishment

Mrs. C.H. (Marion) Gilliland

Women won't admit their age you say? More than 5,000 in Florida proudly and collectively proclaim that they are 55. We are the members of the Florida Medical Association Auxiliary.

Born in Gainesville on May 5, 1926, the Auxiliary was fathered by Dr. H.P. Spengler of Tampa who, inspired by the infant Georgia Auxiliary, spoke to a luncheon group of doctors' wives attending the Florida Medical Association's Annual Meeting.

The first year the infant grew to four organized counties, Alachua, Hillsborough, Palm Beach and Dade. By 1930 there were nine. Organizational expenses of \$69.82 were borne by the first President, Mrs. Wilburn Lassiter, and the first Corresponding Secretary, Mrs. G.U. Tillman, both of Gainesville.

During the depression years of the 1930's membership grew slowly, reaching a high of 253 during that decade. By the mid-1940s there were five new counties bringing in 314 new members. By the end of that decade there were 22 organized counties with a total membership of 884. A most remarkable 347 attended convention that year, just under 40% of the entire state membership!

At the dawn of the 1950s, nineteen of the auxiliaries reported 100% membership. I wish we could say that that is still true. By the end of that decade membership had increased to 2,427, and as the 1950s gave way to the 1960s we had grown to 26 county auxiliaries and 3,138 members. Today we are 27 counties with more than 5,000 members and still growing. If we had 100% of our potential we would be almost twice that number.

The Author

MRS. C.H. (MARION) GILLILAND

Mrs. Gilliland is chairman of the FMA Auxiliary Long-Range Planning Committee, and lives in Gainesville.

From Model T on dirt roads to jet-streaked skies over a populous Florida, the Auxiliary has adapted and coped to meet the shifting scene. Through a decade of economic depression, years of world conflict and changing mores, we have instituted and adapted programs and projects to fill existing needs in our communities and to help the medical profession.

Somehow, it is hard to believe that we began with a frightening visage, but we must have. According to Dr. William H. Rowlett, FMA's 1934 President, FMA members greeted the prospect of an Auxiliary with some trepidation. He remarked to the Auxiliary that year, "How well I remember when they first began to talk about a woman's Auxiliary in our State Association. No one seemed to know very much about it, and they all seemed rather timid about its possibilities. We finally decided to give it a trial, and as one of our members expressed it, he was willing to try anything once. I think most of us were afraid that you women would take our meetings away from us. Some of the more gallant members agreed to keep a watchful eye on you and to guide you."

FMA members were quick to realize that if we could intimidate them we might do the same in the halls of government and they might as well turn that talent to their advantage. As early as 1932-33 members of the Auxiliary were studying Florida's medical and health laws. In Pinellas County their efforts resulted in institution of a much needed county health unit. The next year the FMA requested the Auxiliary's help in defeating bills introduced in the Legislature which would be detrimental to the medical profession. By 1935-36 the FMA challenged the Auxiliary to assist the medical profession in assuring, through a legislative approach, a more adequate solution to the problem of maternal welfare.

Some problems seem to have been with us forever.

As early as 1938-39 the FMA was urging the Auxiliary to become enlightened regarding medical legislation, especially socialized medicine. Doesn't that sound familiar? We may have a few years' respite from that one, but we will be prepared to attack if that monster again rears its head. We also worked hard on the state malpractice legislation during that crisis. Our membership is now quite experienced in writing to congressmen and legislators and they have worked faithfully and enthusiastically to elect those candidates who believe in free enterprise and the private practice of medicine. For the past 14 years we have had an annual "Day in the Legislature" where we are now becoming a recognized influence.

At the FMA's Annual Meeting in 1966 they found they had no spot on their busy schedule for the invited speaker for the newly organized FLAMPAC. The adaptable Auxiliary quickly changed the format of their scheduled luncheon to accommodate the speaker, thus giving birth to the first of many jointly sponsored annual FLAMPAC luncheons. The speaker, incidentally, was the Honorable Doyle Carlton, Florida Supreme Court Justice.

One of our proudest legislative efforts resulted in passage by the 1973 Legislature of a comprehensive health education bill with funding for a three-year study of means for implementation. The Auxiliary had long recognized the need for basic health education in all of Florida's public schools and assumed the leadership for the first statewide health education conference with the cooperation of the FMA, Florida Regional Medical Program, the Department of Education and the Division of Health. Unfortunately, the need has yet to be completely filled. Due to economic conditions at the conclusion of the three-year study, the health education program was funded by the Legislature in an optional rather than a compulsory category and all counties have not given it priority. We still hope to see it compulsory.

Another school project which was highly successful for many years was the sponsorship of health careers. It began with nurse recruitment in 1950-51 and grew into established Future Nurse Clubs with more than 2,000 members. Then these were expanded to include other paramedical fields and the clubs became co-educational. In 1962-63 the name was changed to Paramedical Clubs, continuing the educational and volunteer efforts under sponsors for each club and each hospital in which they worked. During the 1970s the effects of busing and split and double sessions in the high schools made it impossible for many students to participate in club activities. To fill the need left by the disbanding of the Paramedical Clubs, many of the auxiliaries instituted health fairs in an effort to con-

tinue recruitment of health professionals and to disseminate much needed information to prospective students.

Hand in hand with our recruiting of paramedical personnel went our efforts to provide scholarships for students in health fields. Many counties established their own scholarship programs for local schools, and in 1938-39 the first state scholarship loan of \$150 was granted. This effort was continued until the Federal Government began to provide so many outright grants that loans were no longer popular with the students.

The continuing need for scholarship loans for medical students is quite another story. As early as 1952-53 the Auxiliary contributed \$361 to AMA-ERF. Our contributions to this fund have grown dramatically. The second year it leaped to \$1,072; by 1957-58 it was \$4,477; by 1969-70 it had grown to \$16,681.05; by 1971-72 we contributed \$39,887.22; and in 1980 our contribution amounted to a whopping \$70,853.56, with \$27,112.59 of that going to Florida's own medical schools.

Through an annual bazaar, since 1966-67, of crafts made by Auxiliary members and sold within the Auxiliary, we have also raised funds for International Health Activities which included HOPE, Medical Assistance Programs, and SKIP (Scholarships for Kids of International Physicians) which paid boarding school expenses for children of native physicians, enabling them to practice in rural areas of backward countries without sacrificing their children's education. We have most recently been contributing to Interplast East, and we routinely have helped with funds, supplies, clothing and medicine, in areas hit by natural disaster and war.

Our other fund raising efforts have been in the areas of the now defunct Museum of Medical History in St. Augustine and for the Florida Medical Foundation. We have done pretty well there too. Most of the funds for the Museum were raised through the Art Show at the Annual Meeting. Other funds for Foundation projects have been raised through the sale of citrus and seafood packages and the foreign tours, both of which had their beginnings in 1969-70. A few years later we added the proceeds from the sale of two printings of an Auxiliary cookbook.

We have responded to many needs in local communities and in the state as a whole. We have provided much education on drug abuse, venereal disease, smoking, hookworm, malaria, tuberculosis, cancer, safety, child abuse, home health care, mental health, parenting, immunization and physical fitness. We were the moving force behind establishing one county safety council. We train hundreds of babysitters each year and teach many high school girls the

techniques of breast self-examination. We have published and distributed many health information pamphlets. We have participated in many screening programs for hypertension and sight and hearing defects. We presented awards for winning medically-oriented exhibits in the state Science Fairs. During World War II we participated in defense activities and sold more than \$700,000 worth of war bonds.

It is not possible in given space to condense, much less detail, the accomplishments and contributions of thousands of women for more than 50 years and even begin to do them justice. They have accomplished much and are ever ready to do more. The remarkable thing is not that they have done it, but that they have done it all on a very thin shoestring budget. For many years our state dues never rose above \$2.00; then gradually they crept up (over much resistance) to \$3.00 and then \$4.00. For the last few years they have been a whole \$8.00. How else, on a budget of that size could so much be accomplished except through much personal dedication and, in many cases, much personal funding of organization expense.

Almost from the beginning we have worked hand in hand with the AMA Auxiliary as well as the Florida Medical Association. Many of our leaders have been involved on all three levels of the organization, and sometimes all three simultaneously. We have had growing pains, but we have grown.

Our basic objectives have not changed. In writing, we have had to de-emphasize the fellowship which was one of our original stated objectives, in deference to maintaining our tax exempt status with IRS, but it is still one of the great incidental rewards of Auxiliary endeavor. The others, in the beginning were "to extend the aims of the Medical Association, to the wives of the doctors, to other organizations, which look to advancement in health and education;...and to do such work that may be assigned from time to time by the State Medical Association." We state them somewhat differently now, and they are broader and reach deeper into our communities, but they seek the same ends.

The rewards of service are many and lasting. The pride and satisfaction of seeing goals reached and

needs filled, a healthier America, the personal growth, the fellowship of common goals and common problems, and the warm and lasting friendships which come from working together can nowhere else be duplicated. There is still much room to grow and more service to be done. There are many unorganized counties and many spouses of physicians in organized counties who are not members. We stand at approximately 50% of our potential membership and thus also 50% - or less - of our potential impact and service in our communities.

We can still add to our support of medicine, politically and through programs and projects. We can add to our service in our communities, but as Dr. Vernon B. Astler, FMA President commenting on our 50th anniversary in 1976, said:

You've come a long way baby! Reading the opening comment by a fellow physician [Dr. Rowlett's remarks quoted earlier], I would say our attitude toward the Woman's Auxiliary has turned 180° since those early days of your founding some fifty years ago. Today, more than ever, we need the continued and increasing help of the Auxiliary. Women are and should be a powerful, motivating force in our lives in medicine as well as in all other fields of society today. I would ask each of you to continue the traditional support, love and affection which you have always offered on the home front for your physician husbands. I would ask your continued patience when the hours are long and the fuses are short. And most of all, I would ask your continued support in our legislative efforts... Congratulations on your 50th anniversary and hopefully the coming fifty years will be even more rewarding than the past fifty.

Our second 50 began with changing the name of the organization to reflect the new eligibility of husbands of female physicians to join with us in our support of medicine. We are now the Florida Medical Association Auxiliary, having dropped the 'Woman's' designation.

Throughout our entire history there is solid evidence of the Auxiliary and the FMA working together to build and grow. They have frequently requested our help and it has been freely and enthusiastically given. We hope they will continue to ask. It is a tradition we will maintain.

- Mrs. Gilliland, 3031 S.W. 70th Lane, Gainesville 32601.

Action In The Counties

Mrs. L.G. (Mae) White

"The Auxiliary: Powerhouse Potential" was the title of a seminar presented at the 1980 AMA Auxiliary Leadership Conference in Chicago. The fact that the FMA Auxiliary deserves that label becomes quite apparent when one examines the plethora of worthy projects currently being undertaken by auxiliaries in Florida.

It is the conviction of most Auxiliary members that we must demonstrate a concern for the goal of our spouses' profession which is the good health of all people and that we must make some contribution as an identifiable group in our communities along these lines. Also, Auxiliary members feel strongly that we must reflect and carry out the policies of the FMA through appropriate and effective projects.

The specific projects described below are examples of current activities in some of Florida's 28 county auxiliaries. Not all counties are represented and not all worthy projects are included, but these examples should provide some insight into how the auxiliaries are carrying out their lofty goals in the fields of health education, fund-raising, for medically related causes, community service, international health, political action, and health careers.

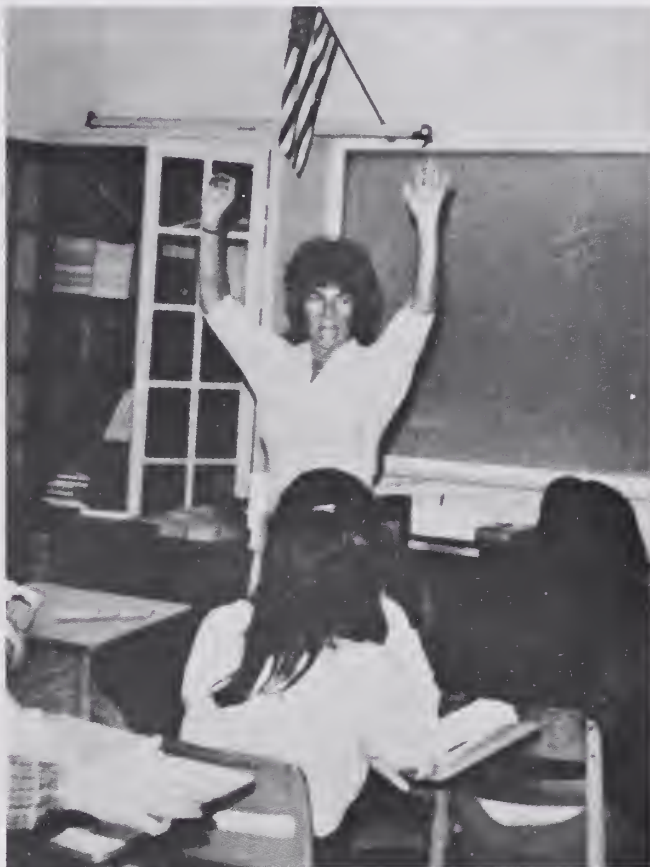
Health Education

The Duval County Medical Society Auxiliary has been sponsoring a breast self-examination program for ninth grade girls since 1973. The program was originally authorized by the FMA, the State Board of Education and the State Cancer Society. It has become a well-established ongoing project of the auxiliary in Duval.

The Author

MRS. L. G. (MAE) WHITE

Mrs. White is chairman of the FMA Auxiliary Health Project Committee, and resides in Ft. Lauderdale.



Mary Ann Matthews of Jacksonville teaches high school students the technique of breast self-examination.

From 3,500 to 3,800 girls are reached each year. All of the public schools, as well as many of the private and parochial schools participate. An auxiliary member, and there are 10 to 12 of them on this year's team, schedules the meeting in her assigned school. She uses the American Cancer Society film, "Something Very Special" in her presentation, which includes informal discussion and questions. The health coordinator or a physical education teacher from the school is present and when possible, a physician. Currently, four doctors are volunteering

their time: Dr. Harvey Bernhardt, Dr. Will Dawkins, Dr. Paul Oberdorfer and Dr. Guy Selander.

Being introduced at this age when breast cancer is highly unlikely, the information has a good chance of influencing the regular health habits of the girls to whom it is presented. It is impossible to evaluate the results of a program which is preventive in nature but one cannot help but believe that the time and effort put forth by these committed volunteers will generate goodwill as well as provide health education.

All the high schools in Escambia County were contacted by the Auxiliary and arrangements were made to show the film, "Something Special" dealing with breast self-examination to 9th grade girls. Approximately 1900 students were reached in one year! Auxiliary volunteers also show the FMA film, "It's Your Life" to area junior and senior high school students and to any interested civic group or organization.

Orange County auxiliaries reached approximately 3000 sixth grade students in their "No Smoking and Marijuana Alert" program by December 1. By using a movie and other visual aids, they hope to make students aware of the health hazards resulting from tobacco and marijuana use. This is a new program this year. The facts that 28% of young people in the 12 to 14 year age group have used marijuana and 47% have smoked cigarettes alerted and alarmed auxiliaries.

The Seventh Annual Total Child Seminar sponsored by the South Branch of the Broward County Medical Association Auxiliary and the Broward County Public School System is to be held on March 27, 1981. The topic this year is "Media and Self-Image - The Impact of TV on Youth." Marie Winn, author of "The Plug-In Drug", Channel 10's Arthur and Company and ACT (Action for Children's Television) will participate. Teachers receive continuing education credit for attending these seminars and the room is always packed!

Although the title was "Women's Forum", men were also welcome to the seminar offered to the community by the South Branch of the Sarasota Medical Auxiliary in February. Beginning with a panel discussion on "Substance Abuse and Rape" which all attended, the meetings continued from 9:00 a.m. unto 2:00 p.m.

A wide variety of health-related subjects such as Loneliness and Depression, Self-Defense, Cardiac Rehabilitation, & CPR, were discussed by professionals in seven different workshops. Participants brought their own lunch. The auxiliary provided coffee and cake for \$1.00

Capital County is also planning a mid-winter seminar to be entitled "Stress in the 80's" and presented to the public free of charge.

Collier County sponsored a workshop and community meeting on "Alcohol and Drug Abuse in Adolescence" in January.

Health Careers

High school seniors interested in a health career were invited to attend a Health Careers Forum at Lee Memorial Hospital in November in Ft. Myers. Sponsored by the Lee County Medical Auxiliary, the forum provided an opportunity for students to learn about the various health careers by talking to professionals, visiting booths, and listening to lectures.

Community Service

In Escambia County, the Auxiliary has participated in the award-winning project, "Meals On Wheels", for seven years now. They are responsible for one complete route seeing that people who live alone and are unable to cook for themselves are provided with one hot meal and one cold meal each week day, holidays included.

A new project developed in Marion County this year is a result of a program which was presented to the members on the nationwide "Vial of Life" program. The goal of the Vial of Life program is to have plastic vials containing emergency medical information placed in refrigerators where Rescue Squads or others having need of this information might have quick access to them. (A sticker on the outside of the refrigerator indicates its presence.) Auxiliaries felt that this emergency identification system was quite valuable to them and their families and friends but they wanted to go a step farther and make it available to others. They approved a project in which they would make themselves available to the Marion County Safety Council in the distribution of the "Vial of Life" information to clients of the Meals on Wheels program. There are currently 14 Marion County auxiliary members actively involved in carrying out this worthwhile new project.

A well-established project in Alachua County is the annual Baby-Sitting Course started 17 years ago. The crime prevention department of the Gainesville Police cooperates with the Auxiliary in offering a three week course to any interested student above the fifth grade level. Certificates are awarded to those who master



Linda Pallin and Diane Gup (above) deliver a hot meal, while Jean Calvert and Babs Conkle (right) load a car with meals as part of the Escambia County Medical Auxiliary community service project.



the objectives of the course which are:

1. To learn to assume responsibility and make decisions without adult supervision.
2. To learn to cooperate with others.
3. To learn how to handle emergencies.
4. To learn ways to entertain children.
5. To learn CPR as taught by an M.D.
6. To participate in a panel discussion with mothers and experienced baby-sitters.

Capital County also sponsors a baby-sitting course. Theirs is done in cooperation with the County Public Library. Auxiliary members and physicians serve as speakers and teach four or five sessions.

Dade County received an award from the Easter Seal Society for sponsoring "The Happy Thursday Club", a club for handicapped adults which meets once a month for a birthday party and Bingo.

Almost too numerous to mention are the auxiliaries which help their local schools with screening tests. North Branch, Broward County Medical Association Auxiliary, does eye, ear and scoliosis testing.

Pinellas County, South Branch, assisted local doctors in giving high school physicals last summer.

Fund-Raising

Many auxiliaries are involved in the raising of

scholarship funds for needy paramedical students.

Central Branch of the Broward County Medical Association Auxiliary, which this year is supporting eleven paramedical students representing an expenditure of \$4500.00, added a novel twist to its Annual Scholarship Fund-Raising event this fall by inviting candidates for local, state and national political office. Most of the candidates accepted. Thus two purposes were served: funds were raised for scholarships and members got better acquainted with the candidates. Incidentally, all the candidates who attended were winners!

In Orange County, the "Kitchen Sorcerer", Charlotte Ann Albertson, presented a program to auxiliary members and their guests at a benefit on February 19, 1981 to raise money for their scholarship fund. An expert in "instant" gourmet cuisine (thanks to do-ahead secrets) Charlotte Ann demonstrated the art of creating easy yet exotic extravaganzas which allow hostesses to relax with their guests, and also hopefully raised a lot of money for needy health careers students.

The West Branch of the Volusia County Medical Auxiliary, with only 30 active members, held an annual fall fashion show in September. Over 300 persons attended and \$3,500.00 was raised for scholarships for students entering a health-related



Estelle Ruben and Cheryl Lentz (above) chat during the Volusia County Medical Ball. Another fund raising effort in Volusia County is the annual fashion show. (right).



profession.

Volusia County holds an annual Medical Charity Ball with proceeds going to scholarships, a Health Science Exhibit for sixth graders and other community health projects. This year's ball was held on November 15 and the theme was "Magnolias and Mint Juleps."

Polk County Auxiliary raised \$1965.00 to give twelve college-bound students scholarships.

Another very popular cause which most of Florida's auxiliaries have raised funds for ever since its inception is AMA-ERF. Florida was third in the nation last year with a total contribution of \$70,853.56. This year's donations are coming in at about the same rate.

Most of the money is raised through the sale of holiday sharing cards but the West Branch of the Broward County Medical Association Auxiliary raised funds through the selling of attractive items, such as the sweatshirts shown in the picture, to its members.

Clay County Medical Auxiliary received an award for its participation in the American Cancer Society's "Send a Mouse to College" program. Almost \$2000.00 was raised for cancer control in Clay County.

A benefit cocktail and dinner party was held in Dade County for the Child Abuse Center and Crises Nursery.

Yet another cause which has motivated fund-raising in most of the counties and which is the recipient of the profits from an annual bazaar at the Fall

Conference is International Health. Most of these funds go to the support of Interplast South with the remainder going to a Disaster Assistance Fund, S.K.I.P. (Scholarships for Kids of International Physicians) and M.A.P. (Medical Assistance Program).

Interplast South has recently widened its scope of patient care by providing needed surgery for patients from underdeveloped countries who had other than



Terry Hunt (left) was the recipient of the Mary S. Day Scholarship Loan, and is shown with Jean Royer, Orange County Medical Society Auxiliary President.



Surgical procedures are provided with the assistance of the Auxiliary through Interplast.



plastic surgery problems although plastic surgery is still the major service performed. A report from Dr. Richard Ott, the program director, gives the following examples:

Pedro Dominquez is a 10-year-old boy from Honduras who was hit by a car five years ago crushing his pelvic bone and severing his urethra at its junction with the bladder. Since then, he has had a super pubic tube in place and many bouts with urinary tract infections. He was flown to Ft. Lauderdale where he stayed with the Torres family while being worked up at Cypress Community Hospital by Dr. Lorrie Epstein. He was then transferred to Shands Teaching Hospital at the University of Florida for the delicate surgical repair he required. Dr. Dixon Walker performed Pedro's surgery and like Dr. Epstein, waived all professional fees. Interplast South incurred the expense

for Pedro's hospitalization at Shands and with generous contributions like those of the FMA Auxiliary, they have all been paid in full.

O.J. Mata, a second case, continues to make good progress after having undergone multiple combined orthopedic and plastic surgery procedures to reconstruct his lower legs and feet in early infancy. He remains here in Florida and is anticipated to undergo at least one more operation in the not too distant future.

In the past year, several other patients have been brought to the Ft. Lauderdale area for needed reconstructive plastic surgery and since returned to their homes in Honduras. North Beach Medical Center and Cypress Community Hospital have been more than generous in their provision of free hospitalization and service for Interplast patients.

The West Branch of the Broward County Medical Association Auxiliary raised funds through the sale of various attractive items and was cause for an amiable gathering of members.



As we look forward to 1981, future operations are scheduled and there are plans for one plastic surgeon to travel to foreign countries to provide service in several developing nations. It is the support of our volunteer families and organizations such as the FMA Auxiliary which allow Interplast South to flourish and to continue providing aid to children who require reconstructive surgery that is not available to them in their home countries.

A three-day International Cooking School will be held in April in Collier County to raise funds for scholarships.

Shape Up for Life

The AMA Auxiliary's three-year "Shape Up For Life" campaign, stressing nutrition, exercise and proper mental attitude was the stimulus for several Auxiliary projects along this line this year.

Residents of Alachua County had a great opportunity to learn about personal fitness on January 28 when the Alachua County Medical Auxiliary and the Gainesville Women's Club co-sponsored a "Shape Up For Life" seminar with an outstanding panel of speakers covering a large variety of topics planned to appeal to all ages. Programs were presented from 9:30



The AMA Auxiliary's three-year "Shape Up For Life" campaign received attention in several counties.



Members of the Broward County Medical Association Auxiliary became involved in an important part of the political process with a voter registration project.

a.m. through 3:00 p.m. with a break for lunch and again from 7:00 p.m. through 9:00 p.m. with only one subject being repeated - Tai Chi. (Relaxing exercises for all ages). Other pertinent subjects covered were: Dental Health, Coping With Stress, Diet For A Healthy Heart, Nutritional Awareness, Aerobic Dancing and Attitudes, Exercise and Diet in the Middle Years. Two sessions were given simultaneously so that participants had a choice of topics.

The seminar was presented to the public free of charge. A nutritional lunch was made available at a reasonable cost by a local health food store - The Hogtown Granary.

An aerobic dance class was Orange County's response to the Shape Up For Life campaign. Classes were held twice a week for 12 weeks and were led by an auxiliary member.

Political Action

The Broward County Medical Association Auxiliary took action when apprised of the fact that a large percentage of the residents of Broward County and fully 50% of the physicians were not registered to vote. Seventeen members, representing each of the four branches, took the course to become Deputy Registrars. Then they undertook the task of register-

ing voters. Some were stationed in hospitals; some in booths in front of supermarkets. They placed signs at their desks stating "This is a public service provided by the Broward County Medical Association Auxiliary" which added a public relations value to the project. Many voters stated they had been meaning to register but had never gotten around to it and thanked the members for making it so easy for them. Through these efforts, literally thousands of persons were registered to vote who would not have done so otherwise.

Statewide the biggest project in the field of legislation is, of course, the annual Day in the Legislature which is described in detail in another part of this article.

Child Abuse and Neglect

Dade County Auxiliary members are participating in the Community Volunteer Advocates Program by representing foster home children in court.

A brochure entitled "Child Abuse and Neglect in Florida" was printed by the FMA Auxiliary and distributed to teachers of grades K through 6 by local auxiliaries last year. It is being rewritten this year by the same professional author for teachers of grades 7 through 9. The state chairman is putting together a packet to be distributed at convention in the spring containing guidelines for ways in which service organizations can become involved in Child Abuse.

Impaired Physician

The Impaired Physicians Committee of the Sarasota County Medical Society Auxiliary, (a large committee composed of 15 members!) motivated by the current interest in that subject, presented Forum - The Family - The Other Victims to its membership in January.

Four speakers were featured at the three-hour seminar held at Doctors Hospital. Mary Beth Wiegang, Chairman of the FMAA Impaired Physician Committee was guest speaker and moderator. Other speakers included: Robert W. Delaney, Alcohol and Abuse Prevention Coordinator, Department of Health and Rehabilitation Services; Forrest Chapman, M.D., Medical Director, Care Unit, Doctors Hospital; Irvin Ellsworth, Program Coordinator, Care Unit, Doctors Hospital.

Miscellaneous

Members of the South Branch of the Palm Beach County Medical Auxiliary will take elementary school age children on tours of the emergency room and the pediatric ward of the hospital for Doctors' Day in '81.

History and Romance of Medicine

The Medical Society and the Auxiliary in Alachua County were the recent recipients of an historical house which is one of the few remaining examples of Victorian Cottage architecture in Florida. The Robb House, as it is called, was home, office and small



Members of the Sarasota County Medical Society Auxiliary's Impaired Physician Committee include (first row, left to right) Mrs. John W. (Robin) Chidsey, Mrs. Alan (Claudia) Porter and Mrs. W. Pearson (Vivian) Clack; (standing, left to right) Mrs. John (Barbara) Freeman, Mrs. John (Janet) Butcher, Chairman, Mrs. Mario (Ione) Salem, and Mrs. George (Bunny) Bishopric.

hospital of the first husband-wife physician team in Gainesville - the Drs. Robert Lee and Sara Lucretia Robb. The Medical Society is in the process of searching for a suitable site for the house which will then be moved and restored for use as a permanent office for the Society, headquarters for the Auxiliary

and a small Medical Museum for public use. '81 will be an exciting year for Alachua as plans develop in this unique project.

- Mrs. White, 2641 N.E. 27th Street, Ft. Lauderdale 33306.



Citrus/Hernando County Forms Auxiliary

The Citrus/Hernando County Medical Society Auxiliary became a constituent of the Florida Medical Association Auxiliary by action of the Executive Committee on September 9, 1980. Pictured above is the Installation of Officers which took place in Crystal River on August 20, 1980. Left to right Mrs. Rex Orr, West Central District Vice President; Mrs. Fred P. Swing, President, Florida Medical Association Auxiliary; Mrs. Carlos Gonzales, President, Citrus/Hernando Auxiliary; Mrs. Ralph Rogers III, Treasurer, Citrus/Hernando Auxiliary; Mrs. Steve Goldberg, Secretary, Citrus/Hernando Auxiliary.

The Auxiliary's Talent Search Program

Mrs. Thomas (Laurie) Busard

The Florida Medical Association Auxiliary (FMAA), at the direction of President, Mrs. Fred P. (Anne) Swing, has organized a program called "Talent Search". This ambitious program has catalogued the many talents of the FMAA members responding to a questionnaire distributed to the membership of the FMAA by the author in her position as project chairman.

The results of Talent Search revealed wide and varied expertise among FMAA members. In addition, it revealed who is willing and able to take on tasks in behalf of the FMAA and/or the FMA, not only at the local level, but also at the state level.

Our various newsletters and magazines, such as the *Beeper*, *Facets*, and our monthly page in *The Journal of the Florida Medical Association*, need writers. We can utilize public relations experts to work with newspapers, radio, television and other media for PR purposes. We need to know who are our invalids, retired persons, and shut-ins who are unable to attend meetings or participate actively. These people need contact on local and state levels. We need to know if we have people capable of carrying out any new endeavors. Talent Search is giving us an inventory of our members who have such expertise.

Results of Talent Search are revealing and rewarding. We have almost unlimited kinds of talent within the FMAA. We have physicians, nurses, flight nurses, clinical psychologists, social workers, physical therapists, biochemists, reading consultants, dieticians, nurse anesthetists, biochemical researchers,

psychiatric social workers, psychopharmacologists, psychologists, speech therapists, clinical consulting pharmacists, and medical assistants. We also have public relations experts, textile engineers, teachers, secretaries (including bilingual secretaries), real estate salespersons, real estate brokers, office managers, advertising managers, hotel managers, accountants, interior decorators and attorneys. In addition, we have journalists, airline stewardesses, anthropologists, singers, dancers, actresses, librarians, educational consultants, bridal consultants, bankers, and marketing managers. Indeed we have a vast array of talent at our disposal.

We are among the best educated women in our state. Many members not only work full time at jobs listed above, but also are involved in numerous voluntary activities. These remarkable women run homes, raise children, keep their husbands happy, and in their "spare time", engage in numerous hobbies, such as tennis, swimming, boating, skiing, golf, art, handicrafts, and little theater. They belong to and are active in symphony guilds, opera guilds, Junior League, Entre Nous, Girls Clubs, historical societies, the League of Women Voters, AAUW, and are museum docents.

We have had over 700 answers to our questionnaire. Information is currently being filed by county with a special file for members at large. They will later be cross-filed, according to need, for use at local and state levels. As an on-going project, new members will be asked to complete questionnaires, and established members asked to update and/or renew the present files.

Last year the FMAA, under the leadership of Mrs. James (Beebe) White, was very influential with our Legislature in Tallahassee. We received numerous accolades, not only from the FMA and individual

The Author

MRS. THOMAS R. (LAURIE) BUSARD

Mrs. Busard is chairman of the FMA Auxiliary Talent Search Committee, and resides in Bradenton.

physicians, but also from members of the Legislature itself. It is the hope of the Auxillary that, with the aid of Talent Search, we can not only duplicate last years' successes, but also go on to other programs for the

benefit of the state, public health and education, the FMA and organized medicine in general.

- Mrs. Busard, 5050 18th Avenue West, Bradenton 33505.

Doctors Are Different

You know better than anyone else the GOOD SENSE NUTRITION of fresh fruit. You also know a good buy when you see one. This Spring, your family can taste the NATURAL SWEETNESS and mouth-watering juciness of FLORIDA'S FINEST CITRUS. A great way to start off each day.

We have again made special arrangements with one of Florida's leading groves to offer you the top 1% of their entire crop. This is the finest gourmet quality fruit available anywhere.

And, don't forget your friends. What more perfect gift for *Easter or Mother's Day than fresh oranges and grapefruit? We'll even GIFT WRAP it FREE. You couldn't ask for anything more convenient. Or more appreciated!

Order Pak #30—1/2 Bushel (\$16.95) or Pak #55 (\$24.95). You may select all oranges, all grapefruit, or a special mix of one half each. For complete selection, write or call for our free brochure.

Brochures may be obtained from your local Chairman or President, or from:

FLORIDA MEDICAL ASSOCIATION AUXILIARY

Mrs. C. Brooks Henderson
1610 S. E. 22nd Avenue
Ocala, Florida 32670
(904) 629-1211

You may order the Fruit Paks mentioned above by sending your check along with this convenient order form, or request brochures for other selections.

Make Checks Payable to: "FMA-AUXILIARY-FMF" and remember, all benefits go to the FLORIDA MEDICAL FOUNDATION.

**DEADLINE FOR EASTER
DELIVERY March 31, 1981**
**DEADLINE FOR MOTHER'S DAY
DELIVERY April 15, 1981**

Delivery cannot be guaranteed on orders beyond these deadlines

PLEASE SHIP THE FOLLOWING TO MY FRIENDS:

NAME _____	PHONE NO _____	PAK NO _____
ADDRESS _____		APT _____
CITY _____	STATE _____ ZIP _____	ARRIVAL DATE _____
<input type="checkbox"/> ALL ORANGES	<input type="checkbox"/> ALL GRAPEFRUIT	MIXED _____ PRICE \$ _____
VARIETY _____		ADD'L SHIPPING \$ _____
FREE GIFT WRAP (SPECIFY) _____		TOTAL \$ _____
COMPLIMENTS OF _____		
NAME _____	PHONE NO _____	PAK NO _____
ADDRESS _____		APT _____
CITY _____	STATE _____ ZIP _____	ARRIVAL DATE _____
<input type="checkbox"/> ALL ORANGES	<input type="checkbox"/> ALL GRAPEFRUIT	MIXED _____ PRICE \$ _____
VARIETY _____		ADD'L SHIPPING \$ _____
FREE GIFT WRAP (SPECIFY) _____		TOTAL \$ _____
COMPLIMENTS OF _____		TOTAL \$ _____

Highlights from *The Auxiliary Beeper*

Mrs. Rod M. (Lita) Martija

Like it or not, this is the age of the politicizing of medicine — a period which understandably leaves the medical community perturbed and frustrated by the seeming loss of public esteem and confidence in the profession.

The Auxiliary's PR Chairman, Mrs. Angus W. Graham of Bradenton, wrote: . . . "It seems our largest headlines deal with malpractice suits, divorce, medicare frauds; our most sympathetic coverage carried on the obituary page. We are on center stage and are easy targets! . . ." Indeed, the potshots are coming in from all sides. This is a critical year. We simply cannot ignore it and sit this one out!

Last spring, State Auxiliary President Mrs. Fred P. Swing echoed a stirring message: "Get Into The Act for medicine!" The role of the medical spouse in community affairs must be re-assessed and revitalized. Mrs. Swing's battlecry resounded across the state to spur some 5,000 Auxilians to become more concerned with issues affecting organized medicine, to be more visible and involved with Auxiliary and other community projects, to be well-informed. "The only way to present the true face of Medicine to the public," she says, "is to act with conviction and communicate from knowledge."

This is the theme that set the tone for the 1980-81 issues of the *Beeper*, the Auxiliary's official newsletter. It recorded Auxiliary activities on county, state, and national levels. It profiled medical spouses getting into the act. It chronicled reports from Auxiliary leaders and state committee chairmen who set guidelines and articulated our common social concerns. There are hundreds more whose selfless commitment to community service had not been written about, nor may ever be. They are all part of the same team, of one "class act". The medical

spouse will never be just a medical afterthought. Auxilians are not mere spectators but skilled participants — they get into the act — and the pages of the *Beeper* served as part of the stage across which they moved!

Here are some excerpts from three *Beeper* issues.

On Legislation —

(By Mrs. James White, State Legislation Chairman, FMAA)

It Worked! We have proven that the Auxiliary is a very viable way to measurably expand the legislative capability of the FMA. Each county responded and we have an active LegsAlert System which was used most effectively during the 1980 Legislature assisting with FMA priority legislation.

On Child Abuse —

(By Anne Kremer, M.S.W., State Vice-Chairman, Child Abuse Committee, FMAA. Mrs. Kremer is also the director of the Parenting Project at the Community Mental Health Center in Winter Haven.)

In December 1980, in Jacksonville, a 15-year old strangled her 3-week old infant because she feared her infant would grow up abused and neglected as she did.

From July to December 1979, 28,169 cases were reported to the Child Abuse Registry in Tallahassee. During this same period, 12 children died in Florida due to child abuse. Normally, only about half the reported cases can be substantiated, meaning that probably 2,350 cases are documented each month in Florida. Reporting statistics are considered to represent only the tip of the iceberg.

Although the general public thinks of child abuse only in terms of physically-abused children, many mental health professionals as well as parent groups (such as Parents Anonymous)

The Author

MRS. ROD M. (LITA) MARTIJA

Mrs. Martija, a resident of Longwood is Editor of the FMA Auxiliary *Beeper*.

insist we view it in broader terms. Parents Anonymous considers physical and mental abuse all to be child abuse and threatening to the well being of our nation's children.

Child abuse and neglect, viewed as chronic disruption in parent/child interaction, may be defined as "any interaction or lack of interaction between a care-giver and a child that results in harm to that child's physical or developmental state."*

The Battered Child Syndrome was identified medically in the early 1950's, and because a definite cluster of symptoms could be identified radiologically, we did focus on this area. Some authorities feel this focus in reporting, and legal involvement of parents and children, has only stressed our limited treatment facilities and already poor family systems.

. . . Child abuse prevention belongs to everyone. it begins with knowing yourself — do your own tensions cause you to pressure your children? Are your expectations and demands placing unreasonable pressures on your own children? . . .

In a pamphlet prepared for the National Committee for Prevention of Child Abuse, entitled, "Child Abuse: A Plan for Prevention", Dr. Ray Helfer, currently a professor in the Department of Human Development, College of Human Medicine at Michigan State University, recommends a three-step intervention program to combat child abuse.

The first part, Perinatal Attachment, can be initiated by physicians in their own communities. It features either volunteers or paid staff support of parents of first born in all aspects of their role.

The second part calls for equally strong support for parents of preschool children, and

The third part is training throughout school years for children in interpersonal skills (skills in "how to get along" with peers, teachers, older children, younger children, authority figures, parents, and siblings.) These skills also include getting along with persons of different races, cultures, developmental skills, and maturity, as well as opposite sex.

*From Helfer, Ray E., M.D., "Child Abuse: A Plan for Prevention", p. 6.

My more positive hope is that by attracting attention to the issue of serious child abuse and neglect, we can highlight that precarious status of children in our society today; their overall development and protection are in grave jeopardy!

On The Impaired Physician —

(By Mrs. Frederick Weigand, State Chairman, Impaired Physician Committee, FMAA; and Member, FMA Committee on Impaired Physicians.)

He does exist!

Our 'conspiracy of silence', misguided protection, the cover-up game, are failures on our part. Worse, these are the tools with which we condemn him!

And from an actual case history published in the October 1980 issue of the Maryland State Medical Journal —

Fear was perhaps the most difficult to deal with, because we had all the ingredients present for an "accident waiting to happen". There was fear of losing our livelihood, fear of involvement in an auto accident where someone might be killed or injured, and, finally, the fear for my husband's physical health which was deteriorating.

It is often difficult for the immediate family to confront and move the alcoholic to get help. I feel tremendous gratitude to an excellent physician/friend who confronted my husband and started him on the road to recovery . . .

. . . Alcoholism is a primary disease. The disease of alcoholism and addiction to other drugs is a treatable disease. The FMA has an available, non-punitive program. So let's get at it! . . .

As a concerned group of caring professionals, the FMA Committee on Impaired Physician is presently meeting regularly in an effort to structure an advocacy program to aid our sick doctors in Florida. An interim director, Dolores Morgan, M.D., has been appointed. The committee is also involved in producing an educational video tool which will be used to instruct all of us on the disease of alcoholism and other chemical abuses as it affects the physician and his family.



Interplast South, Inc., is a non-profit organization based in Fort Lauderdale which provides free reconstructive surgery to international children (mostly coming from South American countries) suffering from birth defects and disfigurements due to accidents. In 1977, FMAA adopted a resolution to support the group with funds raised by the FMAA International Health Committee. Last year, Interplast South received \$5,351.00 from the FMAA. Photo shows one of the children, before and after surgery.

An Update From Interplast South —
(From Anne Lombard, Vice-President, Interplast South, Inc.)

Thank you (Auxiliaries) for all the many things you are doing to help us to continue our work. Our list of repaired-and-mended-and-back-home-again group is growing! A few more young children were recently added. One case was particularly sad and seemed to stand out. They "found" Pedro when our doctors took one of their trips to Honduras. He was run over at the age of two by an 18-wheel truck which crushed his ureters. He left the hospital with a little bag to be with him forever and with no hope for surgical repair. He is now ten years old, very bright, and hopeful of microsurgery.

Your donation goes for so many things — even airplane fare for the children when necessary. We are hopeful, too, for Pedro. And for little O.J., the little baby with burned stumps for feet. Thanks to you, and our volunteer surgeon, O.J. now walks. There are legions on the list.

And there is the moving story of "A New Face For Tomas . . ."

On Marketing Membership —
(By Mrs. N.H. Carpenter, Vice-President, South District, FMAA)

In a marketing sense, factfinding means finding ways to sell a product. Our product is Auxiliary. And while members know the good reasons for belonging, those who are not members do not. So, the first important step is to enumerate benefits and opportunities within the Auxiliary. To state the obvious is an excellent way to revitalize an entire membership.

Planning is always the best way to do the most with the least effort. The Membership Committee should insure that projects are feasible financially as well as enjoyable to members. There should be incentives to work for, recognition of old members planned, ideas presented attractively, birthdays noted, and resource people identified and used.



A Presidential gathering. Above, Mrs. B. David Epstein, immediate Past President of the FMAA, and Mrs. Fred P. Swing, current President pose. Right, Mrs. Swing.



Evaluation is vital. If projects or methods are not producing results, sit back and figure out why . . . !

Why Long-Range Planning? —

(By Marion Gilliland, State Chairman, Long-Range Planning, FMA. Mrs. Gilliland was State President for FMAA 1969-70)

Auxiliary leadership changes every year. With a new administration come new ideas and new approach. Without careful planning, this sometimes leads to confusion and multiple directions.

Long Range Planning conserves the good of each administration and preserves the continuity of purpose and direction. It assures steady progress toward your goals. This does not mean your future is locked in concrete and that you cannot change it. The ability to change is essential in these days of rapid change throughout the whole world. Sometimes it is necessary to quickly revise plans to meet contingencies.

Some prescriptions:

Know your Auxiliary, its talents, resources, limitations, past accomplishments, and how they are achieved.

Know your community, its needs, resources available to you, responses. Know your competition. Are there possibilities for cooperation?

Evaluate your existing methods and objectives. Don't be afraid to throw out what doesn't work. Including people!

Prioritize your objectives. Dream a little. Brainstorm.

Involve your members in planning and hoping. You will need them to achieve your goals and you are more likely to be able to involve them in achieving something they have helped plan.

The rapidity of change these days could be overwhelming if you haven't thought ahead and planned to meet it. Without Long-Range Planning, we are merely sowing the seeds of our own mediocrity!

And From The President's Corner —

(Mrs. Fred P. Swing is the 1980-81 President of the FMAA under whose masterful stage directions the auxiliary's activity scripts are taking fresh and inspired dimensions.)

We need the active participation of every member to accomplish what we must. Do whatever you are qualified to do and give it your best effort. Audition every new and prospective member and write her into your script. There is a part for everyone!

To continue to function at optimum efficiency, you must keep yourself in top condition. Allow yourself the necessity (not the luxury) of quiet relaxation and make daily sensible exercise part of your schedule. Each day, take time

to do something you really enjoy. We know you are looking after your spouse and children. You help friends and, perhaps, even strangers. Auxiliary takes a certain amount of your energy. Civic problems concern you deeply. When there is a job to do, you do it. You are dependable. That is the key word. People depend on you. That is the most rewarding thing in life. Because you are needed by so many, please don't let them down!

... In Florida, the "show" not only must go on — it always does. So, remember, "Don't whistle in the dressing room", get out on that stage, and "break a leg"! ...

- Mrs. Martija, 1231 Arden St., Longwood 32750.



The Florida Delegation, 17-member strong, attended the Annual Convention of the American Medical Association held in Chicago last July. Florida received an award for 10% increase in Membership. It is now the third largest auxiliary in the nation. The AMAA House of Delegates adopted a resolution proposed by FMAA encouraging the inclusion of a mini-will for organ donor designations to be provided on all driver's licenses throughout the country!



Foreground, L to R: Mrs. Arthur Eberly, Mrs. Milton Tignor, Mrs. Irving Fixel. Second row, seated L to R: Mrs. N. H. Carpenter, Mrs. James Corwin, Mrs. B. D. Epstein, Mrs. Frank Coleman; Standing L to R: Mrs. V. A. Marks, Mrs. Thomas B. Thames, Mrs. P. Wimbush, Mrs. Rex Orr, Mrs. Daniel Nunn, Mrs. Walter Jarrell, Mrs. Theodore Sarafoglu, Mrs. Jack Carver, Mrs. Fred Swing, Mrs. R. B. Moore.

And here's a closer look at what the Auxiliary



Mrs. Arnold Spanjers, Past President of FMAA, shown here with Ralph Turlington at the 1980 Florida School Health Conference held October at the Hilton Inn in Orlando. The conference provided opportunities to address issues and problems relating to school health, parenting, and child abuse. Mrs. Spanjers was on the Legislation Panel at the Conference which was co-sponsored by the FMAA.



FMAA President-elect Mrs. Frank Coleman, shown here with Mrs. John Castelli of Clay County, led eleven Florida representatives in a two-and-a-half day jam-packed leadership training and orientation course for auxiliary presidents-elect. The Confluence was held last October in Chicago.



about, what it's doing, and who's doing it . . .

and Mrs. E. Peek at the 53rd Annual Convention of FMAA held last May in Hollywood, Florida. Dr. Peek is President of the Florida Medical Foundation.



Edie Epstein was elected to the National Nominating Committee of AMA. Photo shows Dr. and Mrs. B. D. Epstein.

Mabel Kokomoor wins Peggy Wilcox Award! The seventh auxilian to be so honored, Mabel is the wife of Dr. Marvin L. Kokomoor of Alachua County. The award, named after the late Mrs. Abbott Y. Wilcox of St. Petersburg who served as FMAA president in 1963 to 1964, is given each year to an auxilian who has been selected for her outstanding services to her county or state auxiliary and to her community.

Join the PR Team

Mrs. Angus W. (Wylene) Graham

No news is good news!! For the medical community that is often the best slogan. It seems that our largest headliners in print deal with malpractice suits, divorce, Medicare frauds and high fees. Our most sympathetic coverage is carried on the obituary page.

Whether we like it or not we are an easy target for bad publicity. The community projects we initiate very seldom rate a congratulatory editorial and often are reported on the society page. BSE (breast self-examination) and PALS (baby-sitting instruction) programs receive kindly recognition in the social column, sharing billing with the weekend visitors list, bridge club accounts, etc.

Unfortunately this is the way the press projects our image in the community. In the past, perhaps, this is the way we wanted it, but we are becoming increasingly aware of the importance of good public relations and we are frustrated by the bad press coverage we are receiving in many of our towns and cities. In many cases we are the victims of our own doings. Only through concerted efforts by each of us will the public image of the medical community become a positive and more honest picture of what we really are. We must all pursue an image building program to correct or compensate for our past failings.

PR Defined

"Public relations" technically can be defined as the art or science of developing reciprocal understanding and goodwill between a person, firm, or institution and the public. In a political campaign or in the promotion

of a new product or idea, "PR" means exposure to the greatest number of people in the most positive way. For us in our local auxiliaries, the process of image-changing or enhancement starts with our day-to-day contact with the people in the community. We must project our concern for the problems within our areas by our individual service as well as by responding to those problems by action on the part of the Auxiliary as a whole. Our serious involvement in other local organizations of which we are members is imperative. Gearing the programs of the Auxiliary toward answering the needs and problems of our communities should be our first consideration.

Implementation

How does the auxiliary implement public relations? Organizational public relations start with good internal communications--among members, between the local and state committees and officers. On a larger scale, the network of communications among national and state and local is active. This network is vitally important for the dissemination of information. Our State Auxiliary publication, *The Beeper*, keeps Auxiliary members throughout the state in touch with each other. On the national scene the *Facets* publication is sent to each Auxiliary member. It, likewise, keeps members attune to national projects and meetings.

Both of these news publications give all members a common meeting ground and common bond which facilitates exchange of ideas and support of projects. This structured communication system can be used readily to inform the medical community of needs and impending problems in order to solicit necessary action. At the local level, Auxiliary groups use newsletters, telephone committees and meetings to bring about united efforts by the medical community in solving problems and promoting projects. These PR

The Author

MRS. ANGUS W. (WYLENE) GRAHAM

Mrs. Graham, a resident of Bradenton, chairs the FMA Auxiliary Committee on Public Relations.

techniques are working in bringing the members together.

We Are The "Good Guys"

The next step is convincing our community that we are the "good guys". Knowing the media personnel and what they consider as newsworthy information is essential. We need to consider carefully what impact our projects will have in the community. All of our organizational actions should be evaluated in terms of community need before we seek the assistance of the press.

A visit with our local newspaper editor or reporter covering the medical scene is an appropriate place to start when our group is initiating a project of local concern. If the project is newsworthy based on its effect in our area, wooing of the press should be an easy matter. Most people (press included) will recognize community concern and hard work. Friendly per-

suasion is made simple when dealing with news media if our concerted efforts are community centered.

The Image We Seek

When our community starts to see us as persons willing to help with problems and to recognize us as citizens concerned with the quality of life in our hometown we will have the image we are seeking. The news media mold public opinion, but we must keep in mind that the press likewise responds to public opinion. When we have the public's support we will find the news media reflecting that same feeling. It is not a simple task and there is no short course in getting the image we want or warrant. It requires each member to be on the PR team and it starts now with our individual actions.

- Mrs. Graham, 8012 First Avenue West, Bradenton 33505.

Legislation

Mrs. James G. (Beebe) White

The 1980 elections are settling into history and we have made our choices. The results of these choices are a clear-cut indication for more conservative and less intrusive government - one that will respond to the people. Now that we have made our choices, we must continue to be involved. True representative government requires its citizens to express their views not just at election time, but on a continuing basis.

Over the past few years, we have seen a strong and united Florida Medical Association and Auxiliary effort evolve in many areas, but particularly in legislation and political action. Spouses of physicians are interested in the good of medicine and have the best interest of the medical profession as objectives. Additionally, these are the same people who are very involved in their communities. Some of the active participation by Auxiliary members in legislative and political efforts can naturally be attributed to the women's movement, but much of it is recognition by physicians that the Auxiliary can be a valuable powerhouse. Admittedly, there was concern that Auxilians were the homemakers and the peacemakers not policy makers, but it was soon realized that Auxilians were knowledgeable, dedicated and enthusiastic, and could make a big difference with their involvement.

Recognizing the contributions that Auxiliary members can make, the Florida Medical Association started at the top and made the State Legislation

Chairman for the Auxiliary a member of the Council on Legislation. It has also been recommended that Auxiliary members be placed on local legislative committees, and that they assist in communication with county medical societies and allied groups. To be truly effective, Auxiliary members must be made a member of county and state committees and must be recognized as important, contributing members by both staff and fellow committee members.

A significant portion of the success of the 1980 legislative program can be clearly attributed to the joint efforts of the Auxiliary and the FMA. One of the major contributions the Auxiliary made this past year was in the area of communication. Each county established a Legislative Alert System which could be activated upon direction from the FMA. The county chairman started the LegsAlert in her area and the committee then telephoned the physicians and spouses who had indicated their willingness to respond as needed in contacting their legislators. The effectiveness of this involvement in the 1980 Session was immeasurable.

Additionally, the legislative conference held in Tallahassee each year during the Session has been expanded to include all physicians and spouses who are interested in legislation and political education. There are workshops on how-to's plus time to spend with the legislators. This program has been extremely valuable in expanding the effective involvement at a local level.

While this joint effort of the Auxiliary and FMA has come a long way, there is still room for expansion. Local staff approval, cooperation and understanding of the joint effort are essential. County medical society executive officers need to recognize the importance of involving the Auxiliary, because only our best efforts in legislative action will ensure that everyone will con-

The Author

MRS. JAMES G. (BEEBE) WHITE

Mrs. White is chairman of the FMA Auxiliary Committee on State Legislation, and resides in Ormond Beach.

tinue to receive good medical and health care. Our goals should be to see that good health legislation is introduced and made into law, and that less desirable bills are either modified or not passed. We must be aware of how state and federal legislation affects all of us, and we need to give responsible input to legislators regarding current bills. We must be well informed on issues so we can write, wire, call or in-person communicate to our legislators or congressmen concepts endorsed by the FMA and/or AMA; furthermore, we must be able to correctly inform our friends of the true facts that may be misrepresented by the media.

We must continue to speak out on issues affecting the delivery of quality health care, and take an active role in formulating and advocating programs that will improve the practice of medicine. The entire legislative delegation from each county will hold periodic meetings that we should find out about, attend, and present recommendations. It is also recommended that we meet with our legislators long before the Session begins, and this is another area where Auxiliary members can offer assistance by organizing the meetings, either on a formal or informal basis.

We need to build a coalition of effort - including other groups who are concerned about a particular piece of legislation. This joint involvement is very im-

portant. We cannot afford to be the "silent majority" because silence implies consent. By the same token, take the time to say "Thank you" when your legislators have responded, even though it may not have been the exact response requested. Common courtesy always goes a long way.

The greatest threat to our way of life is posed by extreme apathy; in other words, by citizens who do not care enough to be involved. Participation by citizens, whether as individuals or as members of groups concerned with specific needs, is the keystone of a functioning democracy. Failure to come forward is to permit decisions to be made on the basis of inconclusive information.

We, as members of the Florida Medical Association and Florida Medical Association Auxiliary, have the means and potential to accomplish great things through involvement and legislative action. This, then, is the challenge of the 80's - to have a true representative government and express our views not only at election time, but throughout the days, week and months that follow.

- Mrs. White, 344 John Anderson Drive, Ormond Beach 32074.

How the AMAA Pumps Life Into State and County Auxiliaries

Mrs. Daniel B. (Gloria) Nunn

Since its founding in 1922, the AMA Auxiliary has had one basic purpose — to serve the people of the nation by ensuring quality health and health care for everyone through a federated structure of national, state, and county auxiliaries. Today, the AMAA is a vibrant volunteer organization of 81,000 physicians' spouses who use their multifarious talents to help people achieve and maintain optimum healthy living. Successful implementation of programs is possible only by means of cooperative efforts among all federation components. The national organization, AMAA, functions as an umbrella for the Auxiliary activities, and many programs are aimed at strengthening state and county levels.

Each February, the AMAA sponsors a Regional Cluster Meeting in Chicago for State Presidents and Presidents-Elect. This meeting is designed to bring state officers together for policy briefing, exchange of ideas, and preparation for the annual convention. With the information and training provided, state officers in turn, can better plan their own programs for the coming year.

The Leadership Confluence, held each October, offers indepth workshops for both state and county leaders. Confluence outlines national programs and suggests community projects. It also supplies leadership development sessions and a variety of outstanding seminars dealing with topics of current interest. A total of 368 Auxiliaries attended the 1980 Confluence; of these, 211 were county presidents-elect. It is notable that transportation expenses are paid by national for state leaders attending regional meetings and for county leaders at the Confluence.

AMAA furnishes educational opportunities for all members through continuing education programs at the annual AMA and Auxiliary meetings. Workshops staffed

by professionals cover important subject matter such as fund-raising for AMA-ERF, health projects, membership, and legislation. The FMAA can take pride in the fact that of 500 state delegates attending the 1980 Annual Convention, 17 were from Florida.

Each level of Auxiliary membership receives periodic publications written especially for them. In addition to *Facets* (a quarterly magazine for all members) and *Horizons* (a bimonthly periodical for Resident Physicians' and Medical Students' spouses), AMAA produces *Direct Line Newsletter* and *National News* for the Auxiliary leadership. *Direct Line Newsletter* is sent bimonthly to 8,000 state and county leaders to give them specific program information to aid in community projects. *National News* is supplied bimonthly to 250 national and state leaders in order to keep them abreast of Board decisions, policies, and deadlines. Every six to eight weeks, following meetings of the AMA Council on Legislation, a mailing with detailed information on issues is sent to state auxiliary legislative chairpersons. On at least a quarterly basis, national committee members of AMA-ERF membership, health projects, and legislation correspond with state counterparts to keep them up-to-date with respect to new information.

The AMAA publishes a number of valuable information booklets which are available upon request. These include: 11 package programs on health topics with community program ideas; the Project Bank Catalog with listings of over 750 programs initiated by Auxiliary members; The Marketing Membership Manual with suggestions on how to increase and maintain existing membership; The Legislative Action Workbook with programs to increase activity in both federal and state legislation; and the Auxiliary Guide, a leadership manual printed in two versions (one for state and the other for county leaders). National also develops special publications for specific uses (e.g. the Shape-Up For Life Campaign materials, membership brochures, immunization posters, and publication lists). Since all such publications require

The Author

MRS. DANIEL B. (GLORIA) NUNN

Mrs. Nunn, wife of the Editor of *The Journal*, is Treasurer of the FMA Auxiliary, and lives in Jacksonville.

extensive research, it is important to recognize that a vast resource file has accumulated from which every Auxiliary member can obtain information.

Finally, it should be mentioned that communication from national to state and county Auxiliaries extends to answering all kinds of requests, whether they be tele-

phone inquiries, or letters for specific information. In every way possible, each request is given personal and prompt attention by Auxiliary leaders and/or staff personnel.

- Mrs. Nunn, 5125 Yacht Club Road, Jacksonville 32210.

FMA Auxilian Nominated to AMA Auxiliary Post

Mrs. Linus W. (Jane) Hewit of Tampa has been nominated to serve as Treasurer of the AMA Auxiliary. Elections will be held during the AMAA's Annual Convention in June in Chicago.

Mrs. Hewit is a former President of the FMA Auxiliary, serving for the term 1968-1969. Mrs. Hewit currently serves as Parliamentarian for the FMAA, and has held the position of Southern Regional Vice President to the AMAA.

Her husband is a urologist practicing in Tampa and is a former President of the Hillsborough County Medical Association and the Florida Urological Society.

Till Death Do Us Part

Mrs. F. Norman (Elizabeth) Vickers

Many months ago the noted poet and imaginative writer of children's books, Madeline L'Engle, spoke to a group of women about "change." She discussed the variety of circumstances that bombard our lives daily and necessitate adjustments in the routine of living. The obvious disruptions like birth, sickness, aging, adolescence, marriage and divorce, I thought, can be easily recognized and acknowledged. However, the lesser irritations, like dead auto batteries, burned roasts, forgotten anniversaries, noisy children and tension headaches also dictate some "change" or some rebalancing of the equation of living. It's a matter of degree.

"Change" also implies a "loss." A dimension of our lives is altered and will never be the same again. Miss L'Engle contended that we can cope either creatively or destructively with these disruptions in our lives. One has the choice of experiencing the pain, anger, disappointment, or fear associated with the change; a person grieves her loss and this can enable her to move on to the discovery of healing dimensions and renewed life. Deep within each of us are the creative resources that can guide us. The other alternative is to deny or reject the challenge, seethe in anger, and become blameful. It's a stalemate situation.

There seems to be evidence that in our society there is a growing willingness to negotiate with "change." Bookstores are full of "How To" books; there is an abundance of seminars and workshops that deal with the subject. Professional counselors are in demand.

The change that most of us try to elude is death. There is reluctance to discuss it, to acknowledge its

imminent approach, even to think about it. Only the unique and rare person can watch death's approach, witness its arrival, view its havoc and then creatively survive the experience. Two such people who have done so are Alan Paton and Madeline L'Engle, the discussor of creative ways to cope with change.

*I kissed your still warm face, and said,
sleep well my love. I prayed, may her soul
rest in peace. I did not weep. I set about the
business of preparing your funeral.*

It's been many years since I've read these tender words by Alan Paton from his book *For You Departed*. They are words that sink deep into the swirling waters of the unconscious, only to resurface at appropriate intervals. With each appearance they are more beautiful, more appropriate and more soothing to me than previously.

When Alan Paton's wife of many years died of cancer in 1967, he began his journey down the pathways of grief. Unique to this painful and imperative prelude to his healing was his strong inner urge to write about it.

*I write it because I am compelled to write
it. I do not come into this room and stare at
the paper as I have done so many times
before. I am eager to begin, and if I am
called away, I am impatient to return.*

Thus with his outstanding capabilities of prose, he affirmed her existence and her being.

Mrs. Paton's physical suffering was long. During the year after her death, Alan Paton's loneliness became intense.

*The halcyon days. I write of them with
unbelievable longing to have again what
one cannot have again, so that my desire to
relieve what cannot be relived begins
actually to war against my knowledge, final
and eluctable that it cannot be done. It is a*

The Author

MRS. F. NORMAN (ELIZABETH) VICKERS

Mrs. Vickers is a former nurse-educator and previous contributor to *The Journal*. Her husband is Book Review Editor for *The Journal*.

strange thing to happen to me who have (sic) always tried to live by reason.

There is much reminiscing in Paton's book. He shares with us, the readers, the anxieties of their courtship days, the joys of fulfillment of marriage and, with great candor, some of their emotionally traumatic conflicts. He writes respectfully about her acceptance of his pioneering work in penal reform and about her own activism in the nation's efforts to secure justice in racially troubled South Africa.

*I remember the words written to me....
'she went your road--not an easy one--with willingness, courage and, it seems to me, ungrudging love.'*

He reaches out to each of us:

My advice to all young husbands and wives, and indeed to all husbands and wives, is not to be niggardly with their (sic) words.

It is not an easy task, but the completion of this work of grief brings peace.

I am glad it came to be written. It has in some strange way refined some dross out of me. It has taught me--though this was not my first lesson--to accept the joys and vicissitudes of life, and to fall in love again with its strangeness and beauty and terror.

I have made my song, alleyluya (sic). And may you rest where sorrow and pain are no more, neither sighing, but life everlasting.

Madeline L'Engle, like Mr. Paton, travelled the tortuous pathway from death, through grief, to healing respite by means of her creativity. In a book of personal reflections entitled *The Summer of the Great-Grandmother*, she described the final months of her mother's life. She compared her mother's plunge into senility with a previous experience--a 20-mile toboggan ride she and her mother had taken down a Swiss mountainside, years ago. The guide could keep the vehicle on course but could not slow its descent.

Death may be an ordinary, everyday affair, but it is not a statistic. It is something that happens to people...And I feel the need to reach out to say, 'This is how it is for me. How is it for you?'

Miss L'Engle's mother spent her last summer at Crosswicks, the author's 200-year old home in Connecticut. She was surrounded by her daughter and son-in-law, grandchildren, great-grandchildren and a "bouquet of young girls to tend her, 24 hours a day, seven days a week." It was an environment of love,

attention, flowers, music, stimulating conversations and beautiful countryside.

However, the interloper, death, hovered in the shadows. Atherosclerosis played cruel havoc with the aging woman's body. She became angry, confused and fearful. This prelude to death affected everyone.

Miss L'Engle wrote:

....I look up at the sky and shout at the stars, 'Take her God! Take her!'

....my own angers startle me. My boiling point seems to get lower and lower every day, and it is small unimportant things which cause the volcano to erupt.

It is the nurtured aspects of our lives which can sustain us in time of stress. For Miss L'Engle her love of music and her intensely developed faith in God infused needed strength.

What do I believe, this summer, about death and the human being? I'm not sure. But I know that it is in the language of the fugue not the language of intellectual certainty. And I know that I could not survive this summer if I could not hope for meaning to my mother's life... What that ultimate meaning may be I do not know, because I am finite, and the meaning I hope for is not. But God, if he is God, if he is worth believing in, is a loving God, who will not abandon or forget the smallest atom of his creation.

Miss L'Engle's mother died quietly at the end of the summer. Those who intimately sustained her during her last days shared in a private requiem celebration at Crosswicks. Then she was taken to Jacksonville, her Florida childhood home and that of later years, for a funeral and burial.

Why does the sharing of grief, such as that of Alan Paton and Miss L'Engle, have such a stirring impact? Why does the reader savor various passages? Why does one find solace in them? Perhaps the writer grieves collectively for each of us when she writes of her own experiences with death. Nature demands that we mourn our losses. A part of us goes, never to return. Grieving is an acknowledgement of this. It is the passageway to readjustment, to healing, to wholeness.

To move from grief to a rediscovery of life, of its joys and beauties is an arduous task. It requires much inner strength, desire, determination and capability. Few of us can do it alone. It is then we turn to one who has made this psychic journey.

The writer of memoirs such as these is one who has confronted her own chaotic disarray of emotions that

defy description and cry out for expression. Through the written word, she gives them release. Her creativity leads to restored order, inner peace, and a renewal of life. There is beauty, courage, strength, and a feeling of reconciliation reflected in her prose creation. It is these intangible ingredients that the reader seeks. His own discovery of these qualities is the beginning of his own psychic journey in search of healing and new life.

References

1. Paton, Alan, *For You Departed*. Charles Scribner's Sons, New York, 1969.
2. L'Engle, Madeline, *The Summer of the Great-grandmother*, The Seabury Press, New York, 1979.

• Mrs. Vickers, 3720 McClellan Road, Pensacola 32503.

Editor's note: Madeline L'Engle is a direct descendant of William J. L'Engle, M.D., one of the founders and first secretary of the Duval County Medical Society.

The Florida Physician and His Family In Crisis

Mrs. Frederick J. (Marybeth) Weigand

The Mental Health Department of the American Medical Association has estimated that up to 10% of physicians in the United States may suffer an impairment due to the abuse of alcohol and drugs.

On the National Scene

Forty-seven states have addressed the impaired physician problem by one means or another and have programs in various stages of development. Some are operating via study committees, physician's health and well-being councils, and others via sophisticated intervention and rehabilitation guidelines.

In Florida

In an effort to define the existence and extent of the problems of the impaired physician in Florida, a questionnaire was sent by the Florida Medical Association Auxiliary to all members in October 1979. We hoped that initial impact of the questionnaire would underscore the fact that Florida, as a medical community, has as many impaired physicians as other medical associations. Confirmation of these statistics, we believed, would be of value in determining the need of establishing a state-level impaired physician program. Another purpose of the mailing

was to provide an anonymous forum through which the physician's spouse could relate her personal experiences in living with a substance-abusing physician.

Who Responded to Florida Survey?

The actual return rate of the questionnaire was 17.5% (4,000 sent out; 700 returned). By far the greatest majority of respondents were in the 30 to 50-year-old age group and 13.6% were employed outside the home.

State of Marriage

A series of questions designed to elicit responses regarding marriage and quality of home life produced the following information. The durability of the marriage of our respondents was relatively high; 47.8% had been married over 20 years and 86.2% said this was their first marriage. Regarding the quality of the relationship, 14.7% described it as less than happy and comfortable. In answer to the question, "Do you provide time for family conversation?" 60.2% answered *routinely*. They could have chosen *occasionally* (33.5%) or *never* (4.0%). To the question "Do you feel you have open and honest communication with your spouse?" 86.6% answered *yes* and 11.4% answered *no* or chose to write in their own personal comments such as "some subjects are strictly taboo;" "he simply cannot express his feelings in some areas;" "he thinks we do - I don't."

The Author

MRS. FREDERICK J. (MARYBETH) WEIGAND

Mrs. Weigand is Impaired Physician Chairman for the Florida Medical Association Auxiliary and a member of the Florida Medical Foundation's Committee on Impaired Physicians.

Characteristics of Physicians and Their Families

1. Into what age bracket would you fall:
 - a. 20-30
 - b. 31-40
 - c. 41-50
 - d. Over 50
2. How many years have you been married?
 - a. 1-7 years
 - b. 8-15 years
 - c. 16-25 years
 - d. Over 25 years
3. Into what age bracket would your husband fall:
 - a. 20-30
 - b. 31-40
 - c. 41-50
 - d. Over 50
4. How many children do you have in each of the following age groups?
 - a. Pre-school
 - b. Elementary school
 - c. Junior High
 - d. High school
 - e. College
 - f. Over 21
5. Is this your first marriage?
 - a. Yes
 - b. No
7. How would you describe your marriage?
 - a. Happy
 - b. So-so
 - c. Erratic
 - d. Comfortable
 - e. Troubled
 - f. a and d
8. Do you have a job outside your home?
 - a. Yes
 - b. No
9. Do your activities center around
 - a. Children
 - b. Husband
 - c. Yourself
 - d. Your friends
 - e. Your clubs
10. Do you feel that you are appreciated by your husband
 - a. Often
 - b. Occasionally
 - c. Seldom
 - d. Never
11. Who in your family has the most influence on your children:
 - a. You
 - b. Your husband
 - c. a and b
 - d. Other member of family
12. How do your children feel about their father?
 - a. Afraid of him
 - b. Respect him
 - c. Happy when he is not around
 - d. Look forward to being with him
 - e. b and d
 - f. a and c
13. Would you and your children be happier if your husband were not a physician?
 - a. I think so
 - b. Questionable
 - c. Yes
 - d. No
14. Your children seek advice from their father
 - a. Never
 - b. Occasionally
 - c. Whenever there is a need
 - d. In preference to you
15. Who makes most of the decisions in your house regarding the children and home activities?
 - a. You
 - b. Your husband
 - c. a and b
 - d. Children
 - d. All of these
16. You attend church as a family
 - a. Regularly
 - b. Regularly with you and the children only
 - c. Occasionally
 - d. Only on special occasions
17. You sit down for family meals or holidays
 - a. Never
 - b. Only on Sundays or Holidays
 - c. Occasionally
 - d. Daily
 - e. As regularly as husband's schedule permits
18. You have a family sharing time
 - a. Occasionally
 - b. Routinely
19. Do you feel resentment because you are carrying more than your share of home responsibility?
 - a. Yes
 - b. No
 - c. I don't know
20. You feel that your husband neglects you
 - a. Often
 - b. Out of necessity
 - c. Because he takes you for granted
 - d. Because he is selfish
 - e. Because he considers what you do unimportant
 - f. Never
 - g. Only when his practice demands it
21. Your husband shows his affection to you by
 - a. Buying things
 - b. Taking you out
 - c. Sharing
 - d. Concern
 - e. Sexual intercourse
 - f. All of these
 - g. c, d and e
 - h. Other ways
22. You feel closest to your husband when
 - a. You are making love
 - b. You are sharing thoughts
 - c. You are helping him
 - d. a and c
 - e. All of these
 - f. a, b and c
 - g. You are sharing recreational and other activities
23. Does your husband portray characteristics which you admire in a man?
 - a. Yes
 - b. No
24. You respect your husband
 - a. As a doctor
 - b. As a good provider
 - c. As a man
 - d. For his integrity
 - e. For his intelligence and education
 - f. All of these and others
 - g. a, b, e
25. Do you and your husband enjoy the same types of recreation?
 - a. Yes
 - b. No
26. If a disagreement arises, you usually
 - a. Give in happily
 - b. Give in with resentment
 - c. Try to convince him that you are right
 - d. Sulk until you get your way
 - e. b and c
27. Your husband allows you to have your way
 - a. To avoid an argument
 - b. To please you
 - c. Resentfully
 - d. Never
 - e. He doesn't care
28. Your husband will listen to your problems
 - a. Occasionally
 - b. Attentively and with concern
 - c. Never
 - d. Prefers not to hear them, but listens to please you
29. Your husband makes you feel insecure
 - a. Around people with an education higher than yours
 - b. Discussing business in front of you with his peers
 - c. Praising the talents of his office help
 - d. Around attractive women
 - e. All of these
 - f. None of these
30. Do you think most doctors' wives feel insecure?
 - a. Yes
 - b. No
31. You like being married to a doctor because
 - a. It is prestigious
 - b. You are proud of him
 - c. You have a nice home and are free of real monetary problems
 - d. All of these
 - e. None of these
 - f. He is polished and educated
32. How would you rank the homelife of doctors' families?
 - a. Equal to any profession
 - b. Lacking in love and understanding
 - c. Stressful
 - d. Happy most of the time
 - e. Difficult most of the time
 - e. Difficult for children
 - f. Demanding on wife
 - g. a, d, e, f
 - h. b, c, e, f
 - i. All of these

Defining the Impaired Physician and Our Attitude Toward Him

To elicit feelings and knowledge regarding the substance-abusing physician, the survey asked the spouses to check one of the following responses to complete the statement, "The word 'impaired' when applied to a physician abusing alcohol or other drugs is"....*acceptable because physicians are human beings too* (36.7%); *no comment because I am not involved* (3.2%); *embarrassing* (13.1%); *confusing* (21.8%); *other comment* (15.7%).

A large percentage of Auxilians exhibited a lack of education regarding the disease concept of the addiction problem as it appears in the physician or anyone else for that matter. We must ask ourselves, would the same number of respondents be *confused* or *embarrassed* to learn that many of our physicians also suffer from other illnesses such as diabetes or rheumatoid arthritis? Interestingly, those who chose to write in other comments on their own were either totally against "pussyfooting" around the issue with fancy names "Let's call a drunk a drunk and get him out of

medicine," or were pleading eloquently for help for the troubled doctor and his family. "It's high time we help our own." "Let's stop the big cover up and help one another for a change."

The Florida Situation

In response to the statement, "One out of 10 physicians suffers an impairment due to the excessive use of alcohol or other drugs," two thirds said it was easy to believe because they knew of one or more such problems in their community. Almost 30% doubted the reliability of the statistic feeling that it was either too high or too low. Later in the questionnaire in an effort to have the respondents examine the problem as it might relate to their own area, they were asked directly, "In your own community, are you or your spouse aware of a physician suffering from an impairment due to abuse of alcohol or other drugs?" 62.8% answered *yes*; 34.4% said *no* and 2.6% chose not to answer at all. The high percentage of the unqualified *yes* answers was overwhelming considering the personal, emotional and professional cost involved in ignoring or covering up the abuse and

-
33. Does your husband enjoy (please check as many as apply)
- Women
 - Partying
 - Going out with the boys
 - Participating in a sport
 - Reading
 - TV
 - Carpentry, car remodeling, painting, gardening, etc.
 - Doing things with his family
34. How would you describe your husband's temperament?
- Controlled temper
 - Uncontrollable temper
 - Easy going
 - Easily provoked
 - Irritable
 - a, d, e
 - b, d, e
 - d, e
 - A real doll
35. Has your husband ever struck you?
- Yes
 - No
 - I refuse to answer
36. How does your husband get along with his own family?
- Indifferent toward them
 - Concerned about them
 - Has frequent contact with them
 - b & c
37. Would you classify your husband as a religious man?
- Yes
 - No
38. Your husband's attitude toward women other you is:
- Chauvenistic
 - Kind and considerate
 - Kind and considerate but condescending
 - Expects them to conform to what is considered womanly behavior
 - c, d
 - b, d
39. Is your husband egotistical?
- Yes
 - No
 - I don't know
40. Do you consider yourself egotistical?
- Yes
 - No
 - I don't know
41. Have you, your children, or your husband received professional counseling during your marriage?
- Yes
 - No
42. Does your husband have excessive habits?
- Yes
 - No
43. You have suspected your husband of having an affair
- Never
 - Occasionally
 - Several times
44. Have you ever had an affair?
- Yes
 - No
45. When your marriage is not running smoothly, you
- Blame yourself
 - Blame your husband
 - Blame the children
 - Blame another woman
 - Look for impairment in yourself
 - Look for impairment in your husband
 - Seek counseling
 - a, b, c, d
 - e, f, g
46. If you sought help you would seek help from
- A friend of yours
 - Mutual friend
 - Minister
 - Therapy group
 - Psychiatrist
 - All of these if necessary
47. If your husband will not recognize his problem, you would
- Speak to his closest peer
 - See a psychiatrist
 - Ask your minister for help
 - Find your own outlet and try to ignore his problem
 - Seek a separation or divorce
 - All of these
48. If you had it to do over again, would you still marry your husband?
- Yes
 - No
 - I don't know

addiction problems in the M.D. spouses.

As a follow up, they were asked to choose a response to the question, "If your husband is aware of a colleague's excessive use of alcohol or other drugs, what has he done about it?" The answers were 31.4% *did nothing*; 24.7% *personally tried to help*; 2.8% *reported it to a medical board either state or local*; 1.9% *avoided him completely*; and 28.1% *knew of no one in the community suffering with the problem*. A few wrote in after this last choice, "at this time."

Our Reactions to the Impaired Physician

It appears then that the response of many of us would be to do nothing when faced with the substance-abusing physician first hand. This prevailing response lends support to the "conspiracy of silence" theory as applied to the sick doctor. It is interesting to note that so few people, 2.8%, were prepared to go so far as to report the problem to a governing body which would have as its responsibility the power to revoke the license to practice. This procedure, while protecting the Florida patient, is of course the least effective means of treatment and rehabilitation for the substance-abusing physician. On the other hand, ignoring him will lead to bad health care because this individual, while in an altered state of consciousness, will eventually attempt to treat a patient. Ignoring him will also lead to the ultimate destruction of the physician himself. Addiction, left untreated, is a fatal disease. Suicides, traffic fatalities, lethal overdoses and cross addictions are all part of the pattern. When we try to help the physician addict on a personal level, as 24.7% tried to do, we find, regardless of our good intentions, that many of us are all too inadequate and uninformed to be effective. We feel discouraged and helpless and are usually greeted with hostility and/or denial.

The "Cover-Up" at Home

From the spouse's point of view, many wrote personal comments on the "cover up game." "Would you believe I take his calls sometimes?" "I cannot be the one to turn him in." "The position he takes is that he must either be invulnerable or hide." "I cover up for him as much as possible." "He is drunk frequently, but so far it is only effecting his home life." "I was able to stop drinking myself when I realized that one of us had to be sober to manage."

The Heart of the Matter

Studies indicate that most substance abuse begins

as a result of a crisis, situation or event that happens in our lives. To substantiate this, the questionnaire asked if the respondent could "recall a time or incident that might be associated with the beginnings of excessive use of alcohol or other drugs by her spouse?" 10.9% answered yes, a crucial indication that the Florida Medical Association would be well served in addressing the issue of impairment in its ranks. Of those responding yes, over half were generous enough to share detailed information in essay form. In these writings we find support of the theory that substance abuse may well begin as a social habit, but a well-defined percentage will indeed cross over to a serious addictive state. Therefore we are looking at an insidious disease pattern; although a vast majority of M.D.s still do not classify alcoholism as a primary disease.

The Isolation of the Physician

The resulting isolation which surrounds the suffering physician is even more acute than when chemical abuse occurs in the nonprofessional population. This is emphasized by Dr. G. Douglas Talbott of the Ridgeview Institute of Georgia. The doctor's built-in community stature; his peer relationships and his own private self image all contribute to his sense of isolation when he is in trouble. The "Titanic Syndrome" - I am unsinkable - proves to be his greatest deterrent from seeking help when he most desperately needs it. As one troubled spouse wrote, "How can you tell God he doesn't know what he is doing to himself?" And from another, "We tried psychiatry, but he refused to go anymore. No one but he has the answers." "He seems out of touch with himself."

The Isolation of the Spouse

With most of us doing "nothing" when faced with the impaired physician, we serve to reinforce his sense of isolation. We also succeed in making the doctor's wife feel isolated. "I feel totally alone, knowing he is endangering himself and his patients and his family." "I do not know where to turn for help without exposing the situation badly." "I agonize and wait for a colleague to notice and come to me lest I be accused of betrayal." And from this untenable position of total isolation, we can easily see that the impaired physician, the sick doctor, is completely unable to reach out for help. We, colleagues and spouses alike, have done "nothing" because of our lack of information about the disease of alcoholism and drug abuse, our fear of litigation, our lack of nonpunitive resources and so the circle goes.

Should the FMA Help?

The survey asked, "Do you feel the FMA should establish a permanent, active statewide program to aid the impaired physician?" The overwhelming response was *yes* (76%); *no* (7.6%) and *I don't know* (16%). This positive opinion is further reinforced by the majority of spouses who answered another similar question by stating that, should they need it, they would seek help from *outside* their local community area if it were available.

How?

"What do you think are the most helpful things the FMA could do to aid the impaired physician?" In essay responses to this question, the Auxiliary members wrote with thoughtful determination. "Help him, don't just punish him." "Shouldn't education of the problem of addiction begin at the medical school level?" "Why not have some CME courses on how to handle stress or what addiction really is?" "The alternative would only be to wait until the government steps in and handles the problem for us." "M.D.'s are liable for one another whether they like it or not simply by association, so they must be involved." "I can remember a time when nobody spoke about cancer in the family - shouldn't we be able to get past our inhibitions by now?"

Education regarding early symptom diagnosis for the physician and the spouse seemed to be the leading suggestion. An advocacy program rather than a punitive one was favored in the responses. Early exposure to the pitfalls of "real life in private practice" was recommended at the medical school level.

"Do you feel the Auxiliary should play a part in any program to aid the impaired physician the FMA will develop?" Willing support at the grass roots level of the Auxiliary is indicated by the positive response of 78.8% saying *yes*; 5.3% *no*; and 15.4% answering *I don't know*. In researching the most successful

program of physician rehabilitation in the country, that of the Medical Association of Georgia, we find that use of Auxiliary members has been of great value. The doctor's wife is and always has been recognized as one of the key elements in his support structure. Also, substance abuse will reveal itself at home long before it is ever recognizable at the office or hospital.

Acknowledgements

I am grateful to those who wrote, "Thank God someone is finally asking us." I am grateful also to those who offered critical comments regarding the quality or nature of the survey. All input was worthwhile and appreciated.

I owe a debt of thanks to Mrs. B. David Epstein, President, FMA-A 1979-80, for encouraging me to prepare this questionnaire. A special debt is owed to Mrs. Roger Lewis, Daytona Beach, for her assistance in tabulating the results. And lastly, it has been my pleasure to work these past months with the fine men of the FMA Ad Hoc Committee on the Impaired Physician.

- Mrs. Weigand, 740 Brechner Terrace, Deltona 32725.

Editor's Note: Since this article was prepared, the FMA Ad Hoc Committee on Impaired Physicians made its final report and recommendations to the House of Delegates of FMA, in May 1980. A five-member Committee on Impaired Physicians was then established within the Florida Medical Foundation and was charged with responsibility for implementing a statewide program for physicians impaired by alcoholism or drug addiction. The author was appointed as FMA Auxiliary Representative on this Committee, which is chaired by Guy T. Selander, M.D., of Jacksonville.

Come To The Annual Meeting And Bring Your Spouse

Mrs. Milton (Jo) Tignor

"Get Into The Act" by attending the Annual Meetings of the Florida Medical Association and the Florida Medical Association Auxiliary April 29 - May 3, 1981 at the Diplomat Hotel in Hollywood, Fla.

Many new fun-filled and informative events will take place during the Annual Meeting this year. The program will assure that each physician and spouse can have a fantastic vacation in South Florida while also earning credits. Some of the programs will be offered on a first come, first serve basis; so do not delay making your reservations.

The annual Pre-Convention Auxiliary Board meeting on April 29 will be preceded by a workshop with a guest speaker on "How To Set Up and Manage Your Own Small Business." This should prove to be an interesting way to learn how to make a rewarding investment. Following the Executive Committee Meeting and Board Meetings; at 3 p.m. there will be a chartered bus trip to the big "Fashion Discount Center" in Hallandale. This center is located just a short distance from the hotel. You will find many designer items such as Gloria Vanderbilt, Givenchy, Pierre Cardin and many more at prices that will astound you. Ultra Suede is a speciality of one of the shops. It is a real haven for the bargain shopper or those who like to simply browse.

Bjorn Secher, a nationally known motivational

speaker from Ft. Lauderdale will be the keynote speaker for the opening session of the Auxiliary House of Delegates on Thursday, April 30. Mr. Secher's motto is "Success Is Luck, Ask Any Failure." You will not be sorry that you made the effort to hear this outstanding individual.

Following the Thursday Auxiliary meeting hurry on over to the tennis courts for the first round of the mixed-doubles tennis tournament. All levels of competition are welcome to participate. The finals of the tournament will be held Friday afternoon following the FLAMPAC Luncheon.

More fun is in store for everyone on Saturday morning! All joggers are welcome to participate in the "Family Health Run For Fun" over a 3.1 mile course on the Hollywood Boardwalk near the hotel. The run will begin at 7:30 a.m. There will be a small entry fee and each participant will receive a t-shirt.

For all of the avid golf fans, there will be golf tournament on Saturday for both men and ladies. You may sign up if you pre-register or in the registration area of the meeting.

All of the Frank Sinatra fans can treat themselves to a fabulous evening at the Sunrise Theatre in Ft. Lauderdale. Mr. Sinatra will be appearing there nightly at 8 p.m. April 29 - May 3. Tickets are \$20 for Wednesday, Thursday and Sunday performances and \$25 for Friday and Saturday night performances. Tickets should be purchased very early, directly from the theatre. (Sunrise Theatre, 5555 NW 95th Ave., Sunrise, Florida 33321....telephone 741-7300.) The Sunrise Theatre Restaurant is open adjacent to the theatre.

The Author

MRS. MILTON (JO) TIGNOR, JR.

Mrs. Tignor, a resident of North Palm Beach, serves as Recording Secretary for the FMA Auxiliary.

Available through the hotel, there will be numerous Gray Line Tours to the surrounding areas. On Wednesday there is an all day tour to Miami-Miami Beach with a stop at the fabulous Omni Center for lunch and shopping. Thursday's tour will go to the Miami Parrot Jungle and the Miami Seaquarium. The tour on Friday will visit the Everglades and includes lunch.

For a casual evening of fun, food and spirits the Paddlewheel Queen cruise ship operates up the intra-coastal waterway from Port Everglades to Pompano Beach. The price of the evening is \$16.95 per person including a steak dinner. There is entertainment and dancing aboard ship. Boarding begins at 6:30 p.m. and the ship departs at 7:30 p.m. returning at 10:30

p.m. Reservations can be made by calling 564-7659.

Another exciting event will be taking place during the meeting at the Miami Beach Theatre of Performing Arts. "They're Playing Our Song" will be the play being produced at this time. For tickets contact: Miami Beach Theatre of Performing Arts, 1700 Washington Ave., Miami Beach, Florida 33139.

The upcoming 1981 Annual Meeting, as you can see, promises to be the best and most exciting yet. Y'all come.

- Mrs. Tignor, 901 Country Club Drive, North Palm Beach 33408.

In the Wings . . .

Mrs. Francis C. (Ruth) Coleman

An understudy stands in the wings hoping to get into the act; a president-elect stands in the wings knowing she will be out there. During that waiting time, several things happen: (1) a great amount of observation goes on; (2) plans come together on how to keep that good act going; and (3) the realization becomes ever stronger that your leading role is a small part of the total action of the play.

When Shakespeare said that all the world is a stage, he must surely have included all that goes on backstage.

A project which is waiting in the wings for attention and possible action by physicians and Auxiliary is one involving mental health. The AMA Auxiliary has chosen "Shape Up for Life" as its theme for the third year, this time with the emphasis on mental health. Nearly every community in Florida has mental health projects under way; these we should augment and/or improve.

However, no segment of our society is more in need of mental health programs than our older people. While there are many activities for aging and retirement, there is one area not covered adequately. Little attention has been given to planning ahead for those years that sneak up and catch you unaware.

Whatever your age, this is a program in which "now" is not too soon. According to Dr. James E. Birren, Executive Director of the University of Southern California's Ethel Percy Andrus Gerontology Center, "Those who seem to do best with their lives are thinking ahead. They aren't just letting life happen to them. They nudge it and make what they want happen."

He also says that with our emphasis on getting started, there is little in our society to provide a philosophical basis for a sound life in later years. "We've never had much of a script for the finish."

The Author

MRS. FRANCIS C. (RUTH) COLEMAN

Mrs. Coleman lives in Tampa and is President-Elect of the FMA Auxiliary.

Scripts are available at a very high price for top executives; who better than physicians can help write some others and make them available? This is a field where educational programs both for and by physicians would do much to provide preventive mental health for our older people.

Another subject worth mentioning is the increasing interest of businesses in the health of their employees. Not only are they interested in this from the financial and insurance angles, but they find that the morale and well-being of the employee plays a part in his effectiveness. At the state health legislation meeting in Key Biscayne, January 4-7, Mr. Peter O'Donnell told of the following project which is under way:

At the invitation of Gov. Bob Graham, a number of chief executive officers of some of South Florida's major employers met to discuss what role they could play collectively in stabilizing the cost of health care for their employees. As a result of this meeting, a specific organizational prospectus has been developed for the creation of the Employers' Health Action Coalition of South Florida.

This work group believes that the proposed Coalition can meet its objectives using its involvement as major health care purchasers (they employ over 150,000 individuals) to improve the operation of the health care system in concert with existing government efforts, and as an alternative to expanded governmental regulation.

Additional coalitions are being established in other metropolitan areas of the state. Notice that this group is trying to develop an alternative to government regulation. So far, the involvement of physicians has been modest. Since this program may seriously impact on the delivery of medical care, involvement by physicians and Auxiliary is essential.

- Mrs. Coleman, 16407 Zurraquin Court, Tampa 33612.

Florida Medical Association Auxillary, Inc.
FIFTEENTH ANNUAL BENEFIT ART SHOW

Exhibit Rules and Regulations

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.)
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of \$10 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than April 16, 1981.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Hotel no later than 3:00 p.m. Wednesday, April 29. Shipped entries will be refused.
8. All entries must remain on exhibition until noon Saturday, May 2. They MUST be picked up between **noon and 1:00 p.m., Saturday.**
9. We will not be responsible for entries not picked up by 1:00 p.m., Saturday, May 2, 1981.
10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to AMA-ERF, divided equally among Florida medical schools.

Kindly enter my registration to show in the Benefit Art Show.

Fee of \$ _____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

() A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc.

Size: _____ (H) x _____ (W) To be hung on wall.

() B. Graphics. Include a pen and ink, charcoal, photography, etc.

Size: _____ (H) x _____ (W)

() C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, etc.

Size: _____ (L) x _____ (D) x _____ (H)

() I am the son/daughter of a Florida physician. Age _____

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award," given by the Journal of the Florida Medical Association, will be used on the cover of a future issue of the FMA Journal.

A registration fee of \$10 will be charged for each entry. Make checks payable to:

FMA-A Art Show
c/o Mrs. V. A. Marks
1132 Country Club Drive
North Palm Beach, Florida 33408

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE APRIL 16, 1981.

Judging will take place beginning at 9:00 a.m. on Thursday, April 30, 1981.



Dr. Thames

T. Bryon Thames, M.D., . . . President of the FMA, has been selected Florida Family Physician of the year by the Florida Academy of Family Physicians. As a recipient of this honor, Dr. Thames' name will be placed in nomination for the title of Family Physician of the Year in competition sponsored by *Good Housekeeping Magazine*.

Two Florida physicians . . . have been elected to offices in the Pan American Association of Oto-Rhino-Laryngology and Broncho-Esophagology.

William A. Alonso, M.D., of Tampa, was elected Treasurer, and **Antonio J. Maniglia, M.D.**, of Miami, was chosen Secretary at the organization's 17th Pan American Congress in Santiago, Chile.

Previously, Dr. Alonso received an Honor Award Certificate from the American Academy of Otolaryngology — Head and Neck Surgery for outstanding service in education.

Eduard G. Friedrich, M.D. . . . Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Florida College of Medicine, has been elected Vice President of the American Venereal Disease Association. In this capacity, Dr. Friedrich will assist the organization's President in appointing committees and developing the program for the Annual meeting next November.

The Association is engaged in professional education and research carried out through a scientific publication and scientific sessions.

Former FMA President Leo M. Wachtel, M.D. . . . of Jacksonville, retired from private practice January 30, 1981. Dr. Wachtel had been engaged in the private practice of family medicine in his native city since 1940.

In 1960, Dr. Wachtel was elected President of the FMA, and in 1963, Florida Gov. Farris Bryant appointed him to serve as a member of the State Board of Health. Dr. Wachtel has also served on the Board of Directors of the American Academy of Family Physicians in 1963, after 12 years as a member of the Congress of Delegates, and was elected Vice President in 1975.

The continuing medical education programs . . . of two Florida providers have been reaccruited by the FMA Committee on Continuing Medical Education.

Samuel E. Crockett, M.D., of Orlando, Chairman of the FMA Subcommittee of Accreditation, said accreditation was renewed on January 30 in the cases of the Florida Lung Association and the Tallahassee Memorial Regional Medical Center. The new accreditation period for each is for four years.

By being accredited, providers are authorized to sponsor or co-sponsor with other groups continuing medical education programs and designate them for Category I Credit.

Robert K. Wilson Jr., M.D. . . . Exec. Vice President of the Escambia County Medical Society, has accepted a position as Medical Director of the Charles Henderson Child Health Center in Troy, Alabama. Dr. Wilson, a member of the FMA House of Delegates for several years, leaves a similar post with the Ambulatory Clinic at Sacred Heart Hospital in Pensacola.

Sorrel S. Resnick, M.D. . . . of Miami, served as Guest Editor of the December 1980 issue of *The Journal of Dermatologic Surgery and Oncology*.

Gov. Bob Graham Praises FMA Promotion of Public Health Programs

Gov. Bob Graham headlined the January 31—February 1 FMA Leadership Conference at the Dutch Inn, Lake Buena Vista. The annual program brings county society leadership and others up to date on FMA plans, positions and policies.

In his remarks at a full house luncheon, Governor Graham said he is "pleased at the separate office established for Medicaid, pleased at the medical malpractice reform passed last year and the decentralized institutional medical care now being provided." The Governor commended FMA for continuing to promote public health programs and said he hoped "communications between us continue to be open and honest."

Governor Graham believes the "new health care mission" must be to control the diseases of lifestyle—smoking, drinking, drugs, stress and other abuses. He plans to work for cost effective Medicaid reform and he favors health coalitions. "The role of Government is to make free enterprise medicine work," the Governor stated.

Opening Remarks

In his opening remarks to the conference, FMA

President T. Byron Thames, M.D., of Orlando, summarized the current operation of councils, committees and the FMA staff. He pointed out that with the exception of one addition, the number of councils and committees has been reduced further and the staff is operating with 32 authorized positions as opposed to a previous total of 52.

"The staff cannot operate effectively with less people than we now have. As a matter of fact, at the January meeting, the Board of Governors authorized two new positions. A new East Central Florida field office will be established in Orlando and a field service coordinator hired for the Auxiliary. We have made more and more demands on the Auxiliary, particularly in the areas of legislation and the Impaired Physicians Program. We need to give them better support," Dr. Thames said.

Dr. Thames also recognized Edward R. Annis, M.D., of Miami, and Louis Perez, M.D., of Sanford, for awards they recently received in the AMA Speakers Bureau contest. Dr. Annis placed second as a television talk show guest and Dr. Perez, third as a television talk show host. In addition to plaques, they received \$750 and \$250 respectively which will go to the FMA Speakers Bureau.

Chiropractic Suit

Dr. Annis was called upon to report on the suit by chiropractors against the AMA, the Illinois State Medical Society and the Chicago Medical Society. Dr. Annis came directly to the Leadership Conference after testifying as the only witness for AMA in the suit. After arriving at Lake Buena Vista, Dr. Annis learned the jury had found for organized medicine on all counts.

"They (chiropractors) attempted to draw a web of intrigue, all attributed to medicine. Regardless of where a statement came from about chiropractic, they attempted to show it was part of a plot hatched by AMA. Thanks to background I obtained from FMA, we were able to contrast organized medicine, our training and continuing education with that of chiropractic. You can be proud of



Gov. Bob Graham chats with Mrs. T. Byron Thames of Orlando, wife of FMA's President, while Dr. Thames contemplates the next event on the Leadership Conference Luncheon program.



FMA Secretary Robert E. Windom, M.D., of Sarasota, makes an important point during his talk at the Leadership Conference.

what we have when we need it," Dr. Annis said.

FMA Finances

Reporting on FMA finances and management, FMA Treasurer J. Russell Forlaw, M.D., of Boynton Beach, said, "I am pleased to report that the reorganization of councils, committees and the staff is complete. In my opinion it is not feasible to further reduce our activities."

Dr. Forlaw reported that the Association is in excellent financial condition; however, there was less than a one percent gain in net income for 1980. "We are going to recommend a dues increase at the March Board of Governors meeting and if they approve, it will go to the House of Delegates at the Annual Meeting," he told the audience.

He also reported that due to the planned retirement of W. Harold Parham, D.H.A., Executive Vice President, in 1984, the duties of the Executive Director have been expanded. Also FMA legal counsel will serve as Associate Executive Director with direct supervision of legislative, political education and public relations programs.

Secretary Robert E. Windom, M.D., of Sarasota, reported on FMA priorities for the year, emphasizing there must be "local support for FMA's legislative programs. Physicians need to become aware of and participate in the process or they will continue to be the victims of an uniformed system."

AMA Positions Supported

He pointed out that the Board of Governors has passed resolutions supportive of AMA positions calling for the repeal of HSA's, PSRO with support for PRO instead, the elimination of federal subsidies for HMO's and discontinuation of the National Health Service Corps for which no real need exists.

Dr. Windom told the gathering that he is conducting a personal campaign for more FMA member participation in AMA. Florida's participation is approximately 55% of the FMA membership.

"Remember how a seven-man delegation led by Dr. Joe Von Thron molded AMA policy on Resolution 62? Think how much more effective we could be if our AMA membership was such we could double our number of delegates. You couldn't practice the quality of care you do without AMA's programs," he said.

New RVS Planned

The 1981 Florida Relative Value Studies will be designed to give the working physician and third parties a broad range of useful descriptors for virtually all procedures and services performed, accurate coding and a relative value guide. It will be based on the broadly accepted Current Procedural Terminology, Fourth Edition, with ground rules, modifiers and guidelines coming from CPT-4 and the 1975 RVS.

"The survey technique used previously was felt to be very time consuming and expensive," William W. Thompson, M.D., of Fort Walton Beach, Chairman of the Council of Health Care Financing, said. "Contact was made with Florida Blue Shield and GHI to determine if they could provide information based on physician charge data. It is important to note we are talking about actual physician charge data and not reimbursement data. It was found that a base of forty million individual charges by medical doctors could be utilized."

Specialty medicine representatives have been asked to furnish input to the committee for the new RVS. It is planned for completion late this year.

Florida Physicians' Insurance Reciprocal

In reporting on the activities of the Florida Physicians' Insurance Reciprocal, Vernon B. Astler, M.D., of Boynton Beach, Chairman of the Board, reminded the audience it has been five years since the malpractice crises when no commercial insurance carrier would write the FMA group program.

"Out of necessity we formed our company to provide this coverage," Dr. Astler recalled. "It troubles the Reciprocal Board that some of our colleagues have recently purchased malpractice coverage from a commercial carrier which has re-entered the market with rates it was charging in 1975, before it left this state while requesting a 50% increase, and left many physicians without coverage."

"This same carrier is now demanding rates in excess of 20% in other states in which it is firmly entrenched. If

enough physicians were to abandon our company for this carrier, and your reciprocal no longer existed, then we would have come full circle to the pre-1975 days when we were beholden to the demands of a commercial carrier," he added.

Since the last billing cycle when the 20% increase was announced by the Reciprocal and with a commercial carrier again soliciting business in Florida, 366 physicians have dropped out of the program. Their short-term savings may ultimately prove to be a very expensive mistake in judgement, Dr. Astler speculated.

"Our own program has shown an alarming increase in frequency and severity of claims. Failure to have increased the rates at this time would have seriously jeopardized the financial security of the Reciprocal," Dr. Astler continued. "Since we write no other lines of insurance and since we write only in Florida, we simply cannot subsidize this program with the profits from other lines of insurance or from more profitable states. No other carrier will be able to subsidize Florida physicians for long, for they have to answer to their stockholders."

"After five years of operation, our original commitment of a physician-owned company to provide professional liability insurance in a consistent manner at an affordable cost has not changed," Dr. Astler concluded.

Malpractice Prevention Seminars

A series of general and specialty group medical malpractice prevention seminars will be presented by the Professional Insurance Management Company (PIMCO) staff this year. These are mandatory for all members of the Reciprocal and open to all members of the FMA.

"We learned from seminars presented last year that among those participating, when a claim is made, it is more defensible because these physicians have better medical records, better informed consent, and better documentation of both positive and negative findings," said James W. Walker, M.D., of Jacksonville, President of PIMCO. "Our attorneys tell us that the 'bedrock' of the defense of medical malpractice suits is the physicians' medical record."

James T. Cook, Jr., M.D., of Marianna, Chairman, and Joseph C. Von Thron, M.D., of Cocoa Beach, Vice Chairman, reported on the Florida delegation's activities at the December Interim AMA meeting. Dr. Cook gave a summary of activities as to how the delegation meets, assignments for reference committee monitoring and said the delegation voted unanimously for the resolution to eliminate PSROs.

Medicine's Image in Congress

Dr. Von Thron told the gathering that organized medicine, through AMA, has a strong image in Congress. "If we are going to maintain it then we must maintain a



Vernon B. Astler, M.D., Chairman of the Florida Physicians' Insurance Reciprocal, explains the rate structure and other aspects of the FMA professional liability insurance program.

strong AMA, that means recruitment and involvement," he said. "Medicine is the last positive political force in this country today, the manufacturers can't do it, they will forfeit their subsidies, and the welfare recipient is not about to do it. We must bring our colleagues into AMA and we must all understand that what we are really selling is what America is all about."

Bay Medical School Report

Updates were heard from all three medical schools in the state. William B. Deal, M.D., of Gainesville, Dean of the University of Florida College of Medicine, told the group that William Steward, M.D., has been named Chairman of the Department of Family Health and Community Medicine. He urged all FMA members to become familiar with the GEMNAC report, and pointed out that there are currently 11,000 Americans in foreign medical schools.

Representing the University of South Florida Medical School was James A. Hallock, M.D., of Tampa, Associate Dean. Dr. Hallock stressed the importance of the hearing coming up in New York State concerning the accreditation of foreign medical schools, and praised the cooperation between the Hillsborough County Medical Society and the college.

Bernard Fogel, M.D., of Miami, Assistant Vice President, Medical Affairs, for the University of Miami said his school has been remiss in telling FMA what it is doing. "For example, 70 percent of our graduates stay in Florida," Dr. Fogel stated. "I think part of this is because of the support of the physicians in the community."

"We have established a single standard of care at Jackson Memorial Hospital, where our students and local physicians work side by side administering to more than two-thirds public patients," he added.

Public Relations

"Public relations begins with you, in your office," Dr. Astler said in summarizing FMA public relations activities. He pointed out the manner in which patients are treated by office personnel and the amount of time the physician takes to explain their case have a bearing on the public's image of organized medicine.

Dr. Astler said FMA keeps in touch with the media through such FMA programs as the medical message columns, radio tapes, speakers bureau and the annual editorial visitation. "Our efforts are constant and you must do the same through your county societies for medicine to be heard," he said. He concluded his presentation by showing FMA's latest public education film, "Edge of Life."

FLAMPAC's Success Story

The Florida Medical Political Action Committee (FLAMPAC) was successful in 14 of the 15 state political races it targeted in last Fall's General Election, FLAMPAC President, Frank C. Coleman, M.D., of Tampa reported. Contributing to this success, he said, were increased political education support from FMA, significant local leadership from Auxilians, contributions by physicians to local candidates and the work done by FLAMPAC's field activities coordinator.

"If medicine is to meet the substantial challenges that lie ahead for us, we must insure that FLAMPAC develops into an effective political force in every community in Florida," Dr. Coleman stated. "We must insure that we participate actively in federal and state legislative campaigns in 1982 through involvement of local activists and increase our capability to influence the outcome of the key or target races."

The 96th Congress

The 96th Congress was not a bad one for medicine according to Mr. Wayne Bradley, Vice President of AMA for public affairs.

"As a matter of fact we won one major victory, that of defeating the President's efforts to pass 'price controls' if you please on hospitals," he said. The addition of four Congressional seats in Florida will give organized medicine another opportunity to make an impact in Congress, he commented.

Mr. Bradley continued: "I would suggest to you that in the 97th Congress one issue that probably will lose its funding is health planning. It is a multi-million dollar failure. PSRO is also obviously a target for many budget cutters. This presents both a challenge and an opportunity for a review process by the private sector. As for health care technology, this has probably done more damage to you than any legislation on the books. It is an ominous threat to you to practice and our goal is to seek repeal of

the authority. If we can't do that we want to limit it to evaluating and publishing." Bradley said.

FMA Legislatives Priority

The initial priority objectives in state legislation are budget issues, according to Louis C. Murray, M.D. of Orlando, Chairman of the Council on Legislation. "Most of these relate to public health, a long term commitment of FMA, and without our organization playing an advocacy role, these will likely suffer in the budget 'cut' process as they have in prior years."

An important part of the initial thrust will be for an improvement of the Medicaid fee schedule for physician services in the amount of increased funding of \$30.5 million. "The Board of Governors feels this is an important priority and it is one that we will be actively involving our county medical societies in," Dr. Murray said.

Department of HRS

FMA was credited for its work in public health by Secretary Alvin Taylor of the Department of Health and Rehabilitative Services. "Were it not for the partnership with you, public health in this state would have suffered," he said. "And, I also feel that if you want to ruin public health in Florida, then take local participation out of it." FMA is and has been opposed to the elimination of separate county health departments.

"I ask you to work together with us in that area and several others," Secretary Taylor appealed. "We need a continuing education program for all health professionals in government. We must be concerned about an adequate quality of care in cases such as nursing homes. We may have to close some because it is lacking. Along with training, we must also have better salaries. I like the relationship between FMA and our department and we want to continue to work together."



Florida Governor Bob Graham (third from right) enjoyed a light moment with FMA leaders during his visit to the Leadership Conference on January 31. Left to right: Louis C. Murray, M.D., of Orlando, Chairman of the FMA Council on Legislation; State Rep. Richard S. Hodes, M.D., of Tampa, FMA Immediate Past President; Vice President Gerold L. Schiebler, M.D., of Gainesville; Governor Graham; President T. Byron Thames, M.D., of Orlando; and President-Elect Sanford A. Mullen, M.D., of Jacksonville.

Board of Medical Examiners

In December of 1980, the Board of Medical Examiners once again began determining probable cause regarding complaints against physicians. That was included in the report from the Florida Department of Professional Regulation (DPR) delivered by Mr. Hinton Bevis.

"During the month of December, the board considered 55 cases for probable cause," Mr. Bevis said. "To further protect the public, with the re-emergence of the board's probable cause panel, all cases where emergency suspensions or restriction has been advised will also be considered by the Board's probable cause panel."

DPR also supports the concept of the Impaired Physician Program. A related issue concerns the statute which states that if a physician encounters or is aware of a practitioner who is violation of the Medical Practice Act, he is required to report this matter to DPR.

He continued: "In relating this law to the case of the impaired physician, it is the Department's opinion that if an impaired physician is in an approved rehabilitative program, the treating physician is not required to forward the patient's name to the Department. As long as the impaired physician is in this program, the public is protected."

He said DPR Secretary Nancy K. Wittenberg has personally communicated their position to Guy T.

Selander, M.D., of Jacksonville, Chairman of the FMA/FMF Impaired Physician program.

Impaired Physician Workshop

More than 100 early arrivals at the Leadership Conference attended a two and one-half hour workshop on Friday afternoon sponsored by the Florida Medical Foundation Committee on Impaired Physicians. The program, entitled "Impaired Physician Workshop: Paving the Road to Recovery", was arranged by Mrs. Frederick J. Weigand of Deltona, Auxiliary representative on the Committee.

Guy T. Selander, M.D., of Jacksonville, Chairman of the Committee, traced the Florida Medical Association's involvement with the impaired physician problem from the enactment of the model "sick doctor law" in the late 1960's to the present.

FMA President T. Byron Thames, M.D., of Orlando, stated that the Board of Governors has placed the impaired physician program on the priority list and fully supports it.

Other highlights of the workshop included the initial FMA showing of a new film entitled "Our Brother's Keeper," which dramatized the plight of a successful physician who becomes afflicted with alcoholism; and two Florida physicians who have successfully conquered their own alcohol and drug problems.

Medical Malpractice Prevention Seminars Offered by Physicians' Reciprocal

The Florida Physicians' Insurance Reciprocal has announced a series of Medical Malpractice Prevention Seminars for 1981.

Nine similar programs were conducted throughout Florida in 1979 and 1980. The Reciprocal said all of its members must attend such a program during 1981.

"While it is entirely too early to be certain, we do think that we are seeing fewer claims from those who have attended a malpractice seminar," the Reciprocal said in an announcement.

The Reciprocal has on the schedule for the remainder of the year the following dates with county medical societies: Dade County Medical Association, April 7; Orange County Medical Society, May 16; Hillsborough County Medical Association, March 21; Palm Beach

County Medical Society, May 19; and Brevard County Medical Society, September 8.

Specialty-oriented seminars will be held in conjunction with: Florida Chapter, American College of Emergency Physicians, Jacksonville, March 18; Florida Obstetric and Gynecologic Society, Tampa, September 26; Florida Orthopedic Society, Hollywood, April 30; and Florida Academy of Family Physicians, Daytona Beach, June 20.

For the convenience of members attending the FMA Annual Meeting, there will be a Prevention Seminar on Friday morning, May 1, beginning at 8:00 a.m.

FMA members may earn three hours of AMA Category I Credit by attending one of these seminars.

Pfizer Dialogue Programs to Carry Out Annual Meeting Stress Theme

The highly popular "Dialogue" series will be among those scientific programs accenting the "Stress and Lifestyle" theme at the 107th Annual Meeting of the Florida Medical Association.

"Dialogue" is a meet-the-professor type program sponsored by Pfizer Laboratories at FMA annual meetings for the past several years. According to Calvin W. Martin, M.D., of Arcadia, Chairman of the Annual Meeting Scientific Program Subcommittee, two of the four hours of "Dialogue" this year will be devoted to emotional and stress factors of hypertension, and stress and the diabetic.

Previously, Dr. Martin announced that Joseph B. Trainer, M.D., of Portland, Oregon, had accepted the Subcommittee's invitation to present the theme keynote lecture before a general session on Thursday evening, April 30, at the Diplomat Hotel in Hollywood.

Several of the scientific sections sponsored by FMA-recognized specialty groups will include papers devoted to the Annual Meeting theme.

The scientific program will be co-sponsored by the Medical Education Committee of the Florida Medical Foundation, which has approved the sessions for 20 hours of AMA Category I Credit. And it's free for FMA members.

The following elements of the scientific program have been completed recently:

THURSDAY AFTERNOON, APRIL 30 SECTION ON ORTHOPEDIC SURGERY (SECTION I)

(Co-sponsored by Florida Orthopedic Society and Professional Insurance Management Company)

1:30 to 4:45 p.m.

George J. Fipp, M.D., Jacksonville
James W. Walker, M.D., Jacksonville

Program Co-chairmen

"Medical Malpractice Prevention for the Orthopedic Surgeon"

In addition to being approved for AMA Category I Continuing Medical Education Credit on an hour-for-hour basis, this seminar will also satisfy the requirement that each physician insured by the Florida Physicians' Insurance Reciprocal attend a

malpractice prevention seminar during 1981.

"Outline of Claims and Loss Experience" — Representative of Florida Physicians' Insurance Reciprocal Board of Directors.

"Causes and Prevention of Malpractice Claims (General)" — Legal Department, Professional Insurance Management Company, Jacksonville.

"Causes and Prevention of Orthopedic Malpractice Claims" — Claims Department, Professional Insurance Management Company, Jacksonville.

"First Notice of a Claim" — Claims Department, Professional Insurance Management Company, Jacksonville.

"How to Conduct Yourself in a Claim or Suit" — Legal Department, Professional Insurance Management Company, Jacksonville.

DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories and Roerig Divisions of Pfizer Pharmaceuticals)

1:00 p.m. to 4:30 p.m.

"Emotional Problems in Primary Care" — Joseph Talley, M.D., Clinical Assistant Professor, Department of Family Practice, University of North Carolina School of Medicine, Durham, N.C.

"Treatment of the Ambulatory Asthmatic" — Donald C. McLean, M.D., Clinical Assistant Professor of Pediatrics, Emory University Medical School, Atlanta, Ga.

"Artery Spasm and Ischemic Heart Disease: The Role of Calcium Blockade" — Film with Accompanying Monograph

FRIDAY MORNING, MAY 1 DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories and Roerig Divisions of Pfizer Pharmaceuticals)

8:30 a.m. to 10:45 a.m.

"Hypertension — Emotional and Stress Factors" — J. Caulie Gunnells Jr., M.D., Professor of Medicine, Division of Nephrology, Duke University School of Medicine, Durham, N.C.

"Stress and the Diabetic" — Charles R. Shuman, M.D., Professor and Chief of the Metabolic Service, Temple University Hospital, Philadelphia, Pa.

SEMINAR ON MEDICAL MALPRACTICE PREVENTION

(Co-sponsored by Professional Insurance Management Company)

8:00 a.m. to 10:45 a.m.

James W. Walker, M.D., Jacksonville
Program Chairman

In addition to being approved for AMA Category I Continuing Medical Education Credit on an hour-for-hour basis, this seminar will also satisfy the requirement that each physician insured by the Florida Physicians' Insurance Reciprocal attend a malpractice prevention seminar during 1981.

"Introduction to Florida Medical Malpractice Problem" — Representative of Florida Physicians' Insurance Reciprocal Board of Directors.

"What We as Physicians Do to Get Sued and the Prevention of Suits" — Robert S. Brittain, M.D., President, Medical Liability Consultants Program, Inc., Denver, Co.

"How Do You Win?" — Robert S. Brittain, M.D., Denver, Co.

"How to Make a Cheap Suit Expensive — Fighting too Long, Failure to Cooperate, etc." — Robert S. Brittain, M.D., Denver, Co.

SECTION ON GASTROENTEROLOGY

(Co-sponsored by Florida Gastroenterologic Society)

8:00 a.m. to 10:45 a.m.

Arvey I. Rogers, M.D., Miami
Program Chairman

"Emotions and the GI Tract"

"Gastrointestinal Manifestations of Emotional Illness" — Pedro Greer, M.D., Clinical Associate Professor of Medicine, University of Miami School of Medicine, Miami.

"Globus Hystericus: Some Insights" — Philip Grossman, M.D., Clinical Instructor in Medicine, University of Miami School of Medicine, Miami.

"Irritable Bowel Syndrome" (Panel)

Moderator:

Chester Cassel, M.D., Clinical Professor of Medicine, University of Miami School of Medicine, Miami.

Panelists:

Pedro Greer, M.D., Miami

Carlos Stincer, M.D., Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami.

"Emotional Manifestations of GI Disorders" — Arvey I. Rogers, M.D., Professor of Medicine, University of Miami School of Medicine, Miami.

"Psychogenic Vomiting" — Carlos Stincer, M.D., Miami.

"Peptic Ulcer Disease" (Panel)

Moderator:

Harris D. Shifrin, M.D., Clinical Assistant Professor of Medicine, University of Miami School of Medicine, Hollywood.

Panelists:

Arvey I. Rogers, M.D., Miami

Carlos Stincer, M.D., Miami

SECTION ON EMERGENCY MEDICINE

(Co-sponsored by Florida Chapter, American College of Emergency Physicians)

8:30 a.m. to 10:45 a.m.

Arthur Anderson, M.D., Fort Lauderdale
Program Chairman

"Coral Injuries" — Donald DeSylva, Ph.D., Professor of Marine Biology, Rosensteel School of Science, University of Miami, Miami.

"Shark Attacks" — Samuel Gruber, Ph.D., RSMAS/BLR, University of Miami, Miami.

"Animal Bites in Children" — Don Weiffenbach, M.D., Lake City.

FRIDAY AFTERNOON, MAY 1

SECTION ON RADIOLOGY

(SECTION I)

(Co-sponsored by Florida Radiological Society)

2:00 p.m. to 6:00 p.m.

W. Thomas Hawkins, M.D., Gainesville
Program Chairman

Welcome — Donald R. Hansard, M.D., President, Florida Radiological Society, Tallahassee.

Introduction of Speakers — W. Thomas Hawkins, M.D., Program Chairman, Gainesville.

"Angiographic/CT Correlation in the Suprasella Region" — Ronald G. Quisling, M.D., Assistant Professor of Radiology, University of Florida College of Medicine, Gainesville.

"Angiographic/CT Correlation in Carotid Occlusion Disease" — Preston Lotz, M.D., Veterans Administration Hospital, Gainesville.

"Overview of Myelography" — Preston Lotz, M.D., Veterans Administration Hospital, Gainesville.

"Interventional Neuroradiologic Techniques" — Ronald G. Quisling, M.D., Assistant Professor of Radiology, University of Florida College of Medicine.

SECTION ON PSYCHIATRY

(Co-sponsored by Florida Council of District
Branches of the American Psychiatric Association)

2:00 p.m. to 6:00 p.m.

Leslie L. Mate, M.D., Miami

Program Chairman

"The Differential Diagnosis of Dementia" — Jack Skigen, M.D., Clinical Professor of Psychiatry, University of Miami School of Medicine, Miami.

"Hyperactivity in Children and the Rest of Us" — Michael C. Hughes, M.D., Clinical Associate Professor of Psychiatry, University of Miami School of Medicine, Miami.

"The Psychotic Patient in the Office" — Jorge I. Casariego, M.D., Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami.

"Sleep Disorders in Medical Practice" — Brian L. Weiss, M.D., Clinical Associate Professor of Psychiatry, University of Miami School of Medicine, and Chairman, Department of Psychiatry, Mount Sinai Medical Center, Miami Beach.

"Psychobiology of Depression" — Richard M. Steinbook, M.D., Associate Professor of Psychiatry and Director of Resident Training, University of Miami School of Medicine, Miami.

"Stress and the Expert Witness" — Sanford Jacobson, M.D., Clinical Associate Professor of Psychiatry, University of Miami School of Medicine, Miami.

SECTION ON PEDIATRICS

(Co-sponsored by Florida Pediatric Society)

2:00 p.m. to 5:00 p.m.

Robert H. Threlkel, M.D., Jacksonville

Program Chairman

"The Management of Prolonged Sleep Apnea" — Dorothy H. Kelly, M.D., Department of Pediatrics, Harvard Medical School, Boston, Mass.

"The Relationship Between Apnea and the Sudden Infant Death Syndrome" — Frederick Mandell, M.D., Department of Pediatrics, Harvard Medical School, Boston, Mass.

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)

2:00 p.m. to 5:00 p.m.

Isaac Cohen, M.D., Miami Beach

Program Chairman

"Art and Science" — John B. Miale, M.D., Professor of Pathology, University of Miami School of Medicine, Miami.

Award Presentation

"Stress, Diet and Coronary Artery Disease" — William Roberts, M.D., National Heart, Lung and Blood Institute, National Institutes of Health, Bethesda, Md.

SECTION ON ENDOCRINOLOGY AND GASTROENTEROLOGY

(Co-sponsored by Florida Endocrine Society and
Florida Gastroenterologic Society)

2:00 p.m. to 5:15 p.m.

Paul S. Jellinger, M.D., Hollywood

Stephen B. Novak, M.D., Hollywood

Arvey I. Rogers, M.D., Miami

Program Co-Chairmen

"GI Hormones: An Overview" — Sami Said, M.D., Department of Internal Medicine and Pharmacology, University of Texas Southwestern Medical School, Dallas, Texas.

"GI-Endocrine Clinical Vignettes: Hyperglycemia, Hypoglycemia, Diarrhea and Wheezing"

Moderator:

Paul S. Jellinger, M.D., Hollywood

Panelists:

Stephen B. Novak, M.D., Hollywood

Arvey I. Rogers, M.D., Miami

Sami Said, M.D., Dallas, Texas

"VIP: Current Concepts" — Sami Said, M.D., Dallas, Texas.

"GI and Endocrine Considerations in Peptic Ulcer Disease" (Panel)

Moderator:

Arvey I. Rogers, M.D., Miami

Panelists:

Lawrence M. Fishman, M.D., Miami

Jeffrey B. Raskin, M.D., Miami

Sami Said, M.D., Dallas, Texas

SATURDAY MORNING, MAY 2

SECTION ON RADIOLOGY (SECTION II)

(Co-sponsored by Florida Society of Radiology)

9:00 a.m. to 11:00 a.m.

W. Thomas Hawkins, M.D., Gainesville

Program Chairman

Introduction of Speakers — W. Thomas Hawkins, M.D., Program Chairman, Gainesville.

"Digital Subtraction Radiology" — (Speaker to be Announced)

Resident Papers

A. University of Florida College of Medicine

- B. University of South Florida College of Medicine
- C. University of Miami School of Medicine
- D. Mount Sinai Medical Center of Greater Miami

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgeons)

8:00 a.m. to 12:45 p.m.

M. Felix Freshwater, M.D., Miami
Program Chairman

Welcome — Jack D. Norman, M.D., President, Florida Society of Plastic and Reconstructive Surgeons, Miami.

"Abdominal Wall Reconstruction — New Techniques" — H. Hollis Caffee, M.D., Assistant Professor of Plastic and Reconstructive Surgery, University of Florida College of Medicine, Gainesville.

"Hand Revascularization — Case Report" — Nalin T. Master, M.D., Resident in Plastic and Reconstructive Surgery, University of Florida College of Medicine, Gainesville.

To be Announced — Peter Chatard, M.D., First Year Fellow in Plastic and Reconstructive Surgery, University of Florida College of Medicine, Gainesville.

"Quadriceps Mechanism Muscle Flaps for Difficult Wound Coverage Problems" — Daniel I. Gruver, M.D., and M. Felix Freshwater, M.D., University of Miami School of Medicine, Miami.

"Modern Management of Pressure Sores with Myodermal and Muscle Flaps" — John E. Nees, M.D., and M. Felix Freshwater, M.D., University of Miami School of Medicine, Miami.

"New Techniques of Orbital Plastic Surgery" — S. Anthony Wolfe, M.D., University of Miami School of Medicine, Miami.

"Central Mound Technique for Reduction Mammaplasty" — Clyde R. Balch, M.D., Naples.

"The Soft Breast" (Film) — Lawrence B. Robbins, M.D., University of Miami School of Medicine, Miami.

"Current Problems in Plastic and Reconstructive Surgery of the Breast" (Panel)

Moderator:

Edward Truppman, M.D., North Miami Beach

Panelists:

Clyde R. Balch, M.D., Naples

Lawrence B. Robbins, M.D., Miami

Walter R. Mullin, M.D., Miami

SECTION ON OCCUPATIONAL MEDICINE

(Co-sponsored by Florida Occupational Medical Association)

8:00 a.m. to 11:00 a.m.

Joseph A. Baird, M.D., Belleair Beach
Program Chairman

"Current Topics in Occupational Health"

Welcome — Francis L. Bergquist, M.D., President, Florida Occupational Medical Association, Lakeland.

"Occupational Health Education in Florida Universities" — Nicholas Alexiou, M.D., Director, Division of Occupational Health, University of South Florida College of Medicine, Tampa.

"Alcoholism in Industry" — Frank X. Lawlor, Corporate Consultant, Medical Division, E. I. du Pont de Nemours, Wilmington, Del.

"Life, Stress, and the Lower Back" — Maurie D. Pressman, M.D., Chief Executive Officer, Horizon Hospital, Clearwater.

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)

8:30 a.m. to 12:00 noon

Taylor H. Kirby Jr., M.D., Gainesville
Program Chairman

The Obstetrical and Gynecological Program will be presented by the three departments of OB-GYN of the medical schools in Florida: University of Florida, Gainesville; University of South Florida, Tampa; and University of Miami, Miami.

Correction

A notice in the January issue of *The Journal* gave the incorrect date for the Section on Allergy at the 107th Annual Meeting of the Florida Medical Association.

The Section is scheduled for 8:30 a.m. to 12:00 noon on *Saturday, May 2* — not on Friday, May 1 as indicated on page 50 of the January issue.

Impaired Physician Intervention Workshop In Miami This Month

The Florida Medical Foundation Committee on Impaired Physicians will conduct its first training sessions in intervention techniques in Miami this month.

The two-day "Workshop on Intervention with Impaired Physicians" will be conducted from 8:00 a.m. to 5:00 p.m. on Friday and Saturday, March 27-28, at South Miami Hospital, according to Dolores A. Morgan, M.D., Medical Director for the FMA/FMF Impaired Physician Program. She said the training will be limited to 25 physicians who can attend the entire program.

Graduates of the program will be available at the Committee's request to intervene with physicians impaired by alcohol or drug addiction in an effort to get

them into appropriate treatment programs and return them to full competency.

Enrollment is by advance registration, Dr. Morgan said. A similar program will be held later in the year in central or north Florida.

According to Guy T. Selander, M.D., of Jacksonville, Chairman of the Committee, the March workshop is one of the final major steps toward full implementation of the Impaired Physician Program.

Registration forms for the Workshop may be obtained by contacting Mr. Edward D. Hagan, Florida Medical Foundation, P.O. Box 2411, Jacksonville, Florida 32203, telephone (904) 356-1571.

"Sun 'n Fun" Fly In Needs Volunteer Physicians

A "Sun 'n Fun" Fly In, featuring over 400 War Birds, Classics, Homebuilts, Ultra-lights and an air show, is scheduled for March 15-22 in Lakeland.

Physician volunteers are needed to man the medical center as doctor of the day. Volunteers will be provided with a vehicle and two-way radio enabling them to visit exhibits and the tents of the "Aviation Fly Market".

Physicians volunteering will be called upon only in the event of genuine emergencies.

Physicians interested in volunteering their services should contact B. F. Brokaw, M.D., in Leesburg at (904) 357-1775 (office) or at (904) 787-2329 (home) for further details.

FMA Annual Meeting Program to Schedule Basic Life Support Certification

The Committee on Continuing Medical Education is pleased to announce that basic life support certification training will be provided at the 107th Annual FMA meeting at Hollywood, Florida in April.

The Broward Heart Association is providing the training on Thursday afternoon, April 30, at the Diplomat Hotel. Karen R. Craparo, M.D., of Hollywood, is course director.

This year, two different tracks will be available, including a two-hour curriculum for physicians seeking renewal of their American Heart Association Certification. This program will begin at 1:30 p.m. and conclude at 3:30 p.m.

The standard four-hour curriculum also will be available and will be open to physicians not previously certified, spouses of physicians and other individuals registered for the Annual Meeting.

Each track will have a maximum enrollment of 60, with advance registration requested. Any openings remaining after advance registration will be filled at the door on a first-come, first-served basis.

There is no registration fee. Course materials will be mailed to enrollees who register in advance.

Physicians attending the program may claim two or four hours of AMA Category I Credit, depending upon which program is selected.

The following form should be filled out and mailed to the Broward Heart Association, to arrive no later than April 15, 1981.

CUT ALONG THIS LINE

Advance Registration For CPR/BASIC LIFE SUPPORT TRAINING

I wish to enroll in (check appropriate block).

- ☐ Recertification training for certified physicians (1:30 p.m. to 3:30 p.m., Thursday, April 30). NOTE: Only physicians presently certified by the American Heart Association and seeking renewal of certification will be admitted to this track.
- ☐ Training for physicians not previously certified in CPR, spouses and convention guests. (1:30 p.m. to 5:30 p.m., Thursday, April 30).

PLEASE PRINT:

Name _____
LAST FIRST MIDDLE

Mailing Address _____
STREET or P.O. BOX CITY STATE ZIP

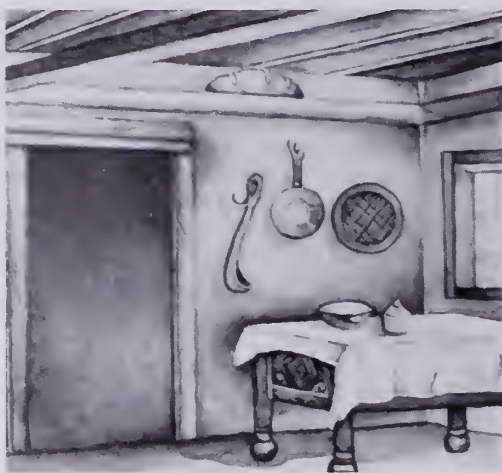
Mail by April 12, 1981: Broward Heart Association
P.O. Box 14213
440 N. Andrews Avenue
Ft. Lauderdale, Florida 33302

Return your registration form as soon as possible so that the course materials can be mailed to you for reading prior to the class date.

CUT ALONG THIS LINE

Yesterday's Folk Remedy:

A rye loaf in the rafters.



Early in this century in Central Europe, almost every farm family kept a loaf of moldy rye bread on one of the kitchen beams. When any family member was cut or bruised, it was an old custom to cut a thin slice from the outside of the loaf, mix it into a paste with water, and apply it to the wound with a bandage. It was believed that no infection would then result from the cut.'



Today's Tradition: **Tegopen**[®] (cloxacillin sodium)

for the treatment* of
known or suspected
staphylococcal
infections such as:

- Acute sinusitis
- Furunculosis and carbuncles
- Impetigo
- Secondarily infected dermatitis
- Cellulitis
- Abscesses
- Infected sebaceous cysts

In serious, deep-seated
staph infections, 500 mg
q.i.d. dosage is
recommended.[†]

- Tegopen has been reported active against 96% of *Staphylococcus aureus*.²
- 80% of *S aureus* has been reported resistant to amoxicillin and ampicillin. ‡²
- 88% of *S aureus* has been reported resistant to penicillins G and V. ‡²
- Staph resistance to erythromycin may develop during a course of therapy.³



Available as 500-mg and 250-mg capsules
and Oral Solution 125 mg/5 ml.

Tegopen[®] (cloxacillin sodium) Today's Penicillin for Today's Physician

1. Florey HW, Chain E, Heatley NG, et al: *Antibiotics*. London, Oxford University Press, 1949, p 2
2. Bac-Data Bacteriologic Report, Professional Market Research, 1978-1979. The clinical significance of *in vitro* data is unknown.
3. Erythromycin prescribing information (in *Physicians' Desk Reference*, ed 34 Oradell, NJ, Medical Economics Co, 1980) states that staph resistance may develop during treatment.

See brief summary of prescribing information on
an adjoining page.

Copyright © 1981, Bristol Laboratories

*Note: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin.

†In serious, life-threatening infections, oral preparations of the penicillinase-resistant penicillins should not be relied on for initial therapy

‡Not all isolates may have been tested using both discs.

Tegopen® (cloxacillin sodium)

Capsules and Oral Solution

Brief Summary of Prescribing Information

For complete information, consult Official Package Circular
(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg q 6h

Children: 50 mg /Kg /day in equally divided doses q 6h. Children weighing more than 20 Kg should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B. INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg, in bottles of 100; 500 mg, in bottles of 100
Oral Solution—125 mg /5 ml in 100 ml and 200 ml bottles

BRISTOL®

Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201

A Public Service of This Magazine
& The Advertising Council

Ad Council



Your Business can be one too.

Red Cross needs individual volunteers, and donors of blood and money, by the millions.

But we need even more help. We need the solid support of American Business. And we never needed it more.

If your business is already helping, by organizing blood drives, and by supporting payroll deductions—either directly for the Red Cross, or through the local combined fund drive—the whole community owes you thanks. And we thank you, too.

Last year, with help from our friends, we offered major aid at over 30,000 disasters—from typhoons, to local (but just as devastating) house fires.

We were able to help the elderly with practical programs, we helped veterans by the hundreds of thousands, we taught people by the millions to swim or swim better. And that's just the tip of the iceberg.

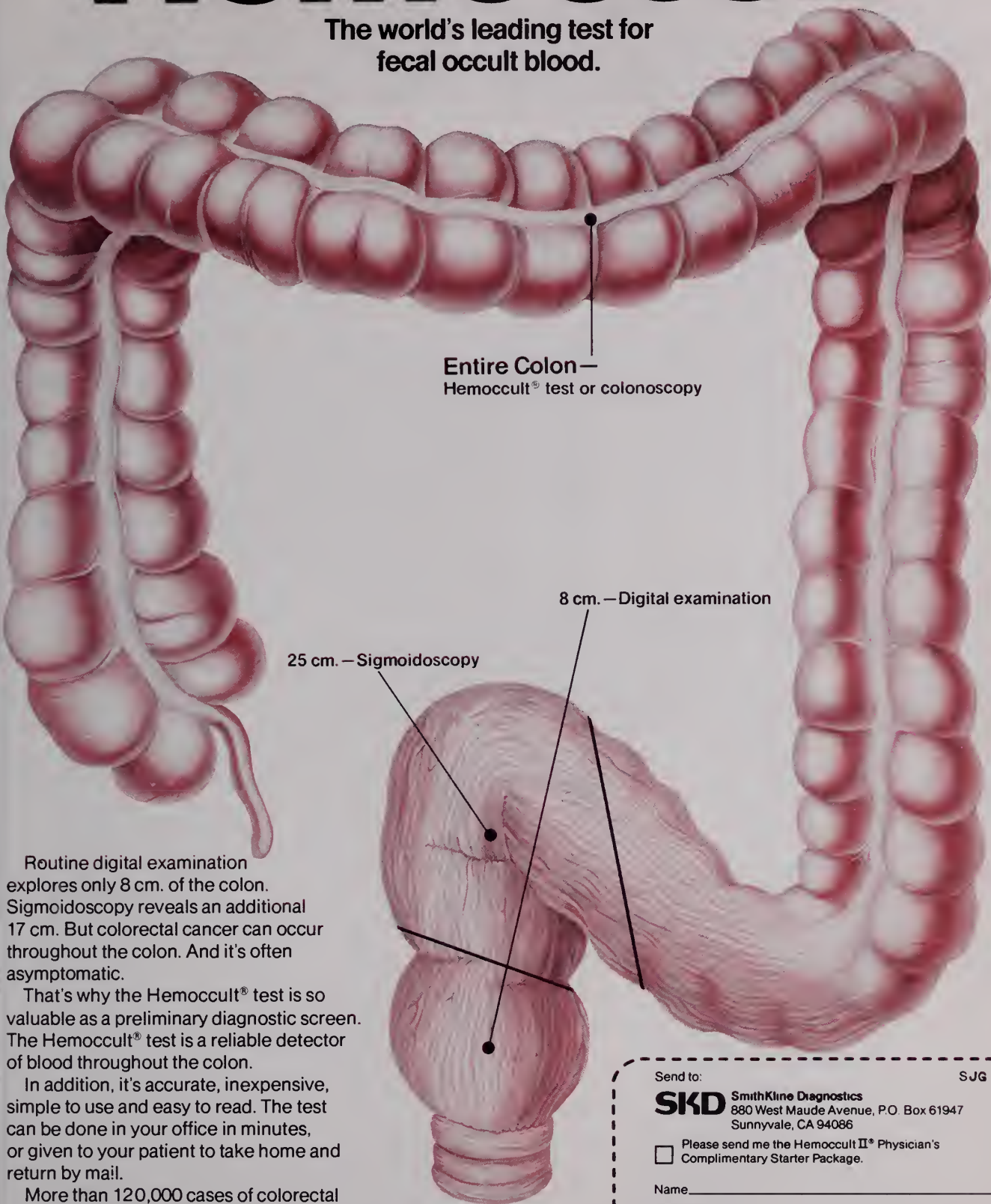
Think of America without The American Red Cross.

And you'll know why we need your business as a Red Cross Volunteer. In your community. And all across America. Contact your local Red Cross Chapter to see how your company can become a volunteer.

**Red Cross is counting
on you.**

Hemoccult®

The world's leading test for
fecal occult blood.



Routine digital examination explores only 8 cm. of the colon. Sigmoidoscopy reveals an additional 17 cm. But colorectal cancer can occur throughout the colon. And it's often asymptomatic.

That's why the Hemoccult® test is so valuable as a preliminary diagnostic screen. The Hemoccult® test is a reliable detector of blood throughout the colon.

In addition, it's accurate, inexpensive, simple to use and easy to read. The test can be done in your office in minutes, or given to your patient to take home and return by mail.

More than 120,000 cases of colorectal cancer will occur in the United States this year. The earlier they are diagnosed, the greater the chances for successful treatment. Send for your free Hemoccult® starter package, today.

Hemoccult® is available through local distributors, nationwide.

Send to:

SJG

SKD

SmithKline Diagnostics
880 West Maude Avenue, P.O. Box 61947
Sunnyvale, CA 94086

☐ Please send me the Hemoccult II® Physician's
Complimentary Starter Package.

Name _____

Medical Specialty _____

Address _____


City _____ State _____ Zip _____

Phone _____



Acute pain is no laughing matter.

The first prescription for the first days of acute pain **Empirin® \bar{c} Codeine #3**


Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). 

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin \bar{c} Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin \bar{c} Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin \bar{c} Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming.) 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

This publication is available in microform.



University Microfilms International

Please send additional information for _____
(name of publication)

Name _____

Institution _____

Street _____

City _____

State _____ Zip _____

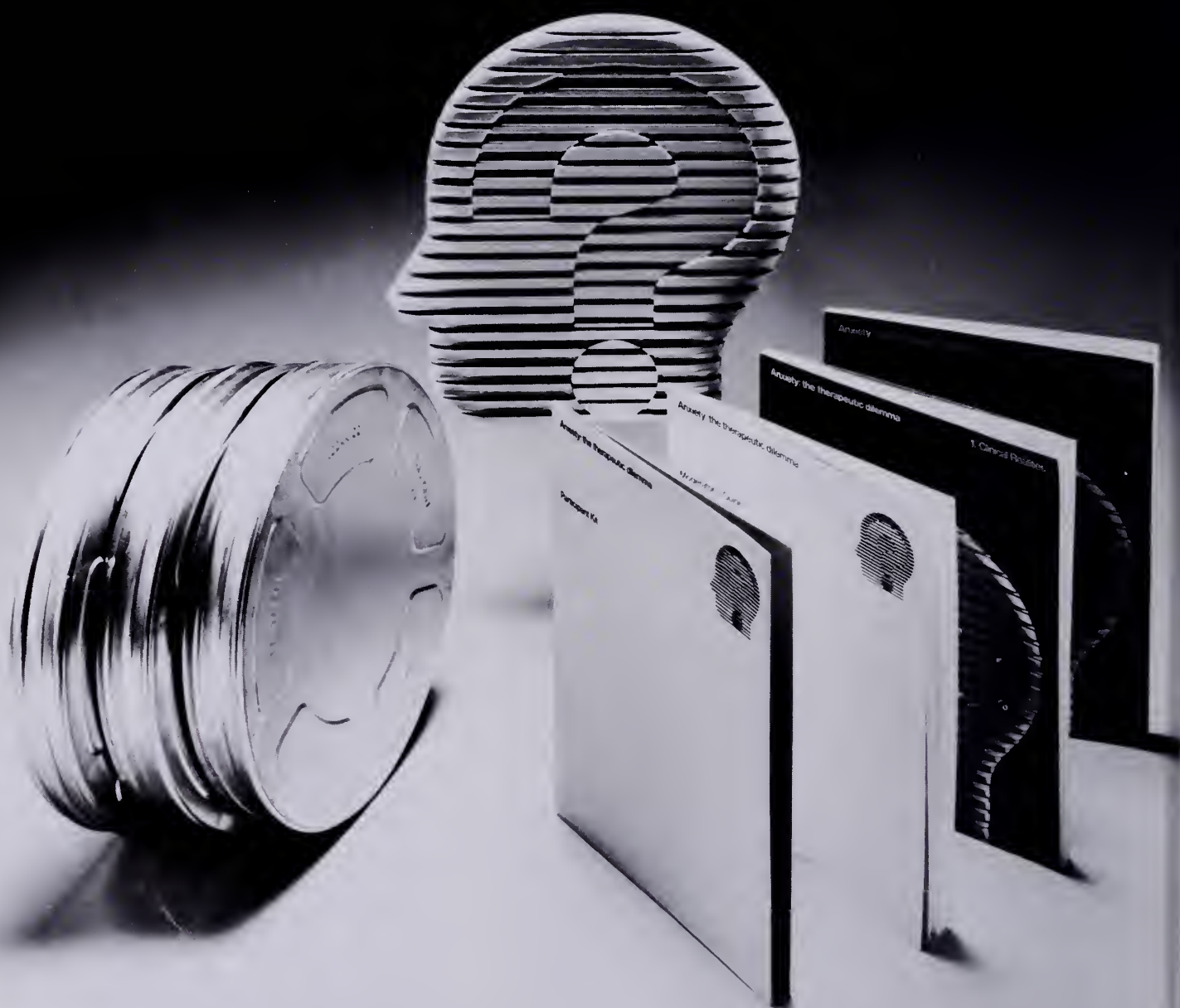
300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

**Now...today's issues
in anxiety management
are confronted in a unique program
for primary care physicians**

Anxiety: the therapeutic dilemma

Multimedia Continuing Education Program



Ideas about anxiety management are changing. Problems have surfaced. There is concern about dependence on minor tranquilizers and new findings on receptor sites in the brain. There is a trend toward short-term therapy and interest in nondrug alternatives. Because anxiety can disable, the need to treat continues in daily practice. Primary care physicians require up-to-date information. This program can provide it.

Current Views and Opinions from Eminent Authorities

Offered free of charge, this multimedia seminar is based on a major symposium. It integrates the views of nationally known clinicians with case material to demonstrate: 1) keys to differential diagnosis, 2) recognition and management of dependence-prone patients, 3) ways to minimize tranquilizer dependency, 4) guidelines for selecting drug and nondrug therapies, 5) how the biochemistry of anxiety can affect treatment modalities. And more.

CME Accreditation

The complete program, **Anxiety: the therapeutic dilemma**, is designed to provide up to a total of 26 credit hours in Category 1, PRA/AMA. The maximum number of hours may be obtained as follows:

Seminar(s)

When presented by an accredited CME provider (hour for hour) . . . up to 8 hours

Self-Study Programs

Designed to provide credit hours indicated when completed according to instructions:

- Two monographs (completed as a unit) . . . up to 6 hours
- Six self-study units (2 hours each) . . . up to 12 hours

Unique Interactive Format Stimulates Participation

More than a conventional lecture, this seminar provides opportunity (and guidance) for the kind of interaction that promotes understanding and anchors useful ideas. Guest lecturers are available and all elements needed for an effective program are included: films, moderator's guide, participants' workbooks, monographs, publicity material, etc.

Flexible Program Design

Anxiety: the therapeutic dilemma is a versatile program with an outstanding faculty, pertinent content and lively format. It can be conducted in a variety of ways to meet your scheduling needs: • Full day — 8 hour seminar • Half day — 4 hour seminar • 1 or 2 hour course

For further information, mail the coupon below, or call toll-free 800-526-4299. In New Jersey, call (201)-636-6600.

Anxiety: the therapeutic dilemma

was produced under a grant from Abbott Laboratories



1-0791 1033394

A-3/81

M.E.D. Communications
655 Florida Grove Road
Hopelawn, NJ 08861

Please send me full details on faculty, agenda, accreditation and booking for the CME seminar, **Anxiety: the therapeutic dilemma**.

Name _____

(please print)

Title _____

Institution _____

Street _____

City _____

State _____

Zip _____

Alert and
functioning
in the
sunset
years

Treat the symptoms in
the geriatric patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule contains:

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

APRIL

Hypertension and Cardio-renal Function in the Elderly, Apr. 2-3, Konover Hotel, Miami Beach. For information: Barry J. Materson, M.D., 1201 Northwest 16th Street, Miami 33125.

"Crisis Control Workshop", Apr. 3, Harley's Sunrise Inn, Ft. Lauderdale. For information: Cathryn Liberson, Ph.D., 2101 North 37th Avenue, Hollywood 33021.

Clinical Management of Coronary Disease & Exercise Testing, Apr. 3-5, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive, East, Englewood, Colorado 80112.

Advanced Cardiac Life Support, Apr. 4-5, Pasco-Hernando Community College, New Port Richey. For information: James M. Marlowe, M.D., P.O. Box 1058, New Port Richey 33552.

Biologic Control of Human Cancer II, Apr. 4-5, Auditorium, North Ridge Hospital, Ft. Lauderdale. For information: W. O. Russell, M.D., c/o Barbara Chandler, 5757 N. Dixie Highway, Ft. Lauderdale, Florida 33334.

Comprehensive Review Course: ECFMG, VQE, and FLEX (in Spanish), Apr. 6-July 17, UM/Jackson Memorial Hospital, Miami. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Conferences in General Medicine and Family Practice, Apr. 8, International Medical Center, HMO, Miami. For information: Alfredo Crucet, M.D., and H. Childs, ARNP, P.O. Box 016700, Miami 33101.

Critical Care Medicine '81, Apr. 9-11, Dutch Resort Hotel, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1414 S. Kuhl Ave., Orlando 32806.

Family Practice Weekend, University of Florida, Apr. 10-12, J. Wayne Reitz Union and Gainesville Holiday Inn, Gainesville. For information: E. Scott Medley, M.D., 625 Southwest 4th Avenue, Gainesville 32601.

Conferences in General Medicine and Family Practice, Apr. 13, International Hospital, Miami. For information: Alfredo Crucet, M.D., and Heather Childs, ARNP, P.O. Box 016700, Miami 33101.

Atrial and Ventricular Arrhythmia Management Update, Apr. 16-18, Belleview Biltmore, Clearwater. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Update on Current Topics of Interest in Anesthesia, Apr. 25-26, Howard Johnson Motel, Pensacola Beach. For information: Warren W. Sears, M.D., 1717 N. "E" Street, Suite 205, Pensacola 32501.

MAY

Cardiology for the Primary Care Physician, May 7-9, Hyatt Regency, Sarasota. For information: Leonard S. Dreifus, M.D., Joel Morganroth, M.D., Lankenau Hospital, Philadelphia, PA 19151.

Seventh Annual Advances in Neonatal and Pediatric Respiratory Care, May 7-9, Sheraton Sand Key Hotel, Clearwater Beach. For information: Robert Cavanaugh, M.D., All Children's Hospital, 801 6th Street South, St. Petersburg 33701.

ECG Interpretation and Arrhythmia Management, May 8-10, Don Cesar Hotel, St. Petersburg. For information: Stephen E. Mattingly, 64 Inverness Drive, East, Englewood, Colorado 80112.

Conferences in General Medicine and Family Practice, May 11, International Hospital, Miami. For information: Alfredo Crucet, M.D., and Heather Childs, ARNP, University of Miami, Department of Family Medicine, P.O. Box 016700, Miami 33101.

Conferences in General Medicine and Family Practice, May 13, International Medical Center, HMO, Miami. For information: Alfredo Crucet, M.D., and Heather Childs, ARNP, P.O. Box 016700, Miami 33101.

Human Sexuality, May 14-16, Gainesville Hilton, Gainesville. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Personality Adaptation Theory Used in Working With Couples and Families, May 22, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Fort Walton Beach 32548.

Master Approach to Cardiovascular Problems, May 29-31, The Contemporary Hotel, Walt Disney World, Lake Buena Vista. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

JUNE

14th Annual Physicians Workshop in Electrocardiography, June 9-16, Los Lebreros Hotel, Seville, Spain. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg, 33705.

Annual Homecoming Symposium (Psychiatry), June 12-13. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

6th Annual Suncoast Pediatric Conference, June 14-17, Sheraton Sand Key, Clearwater Beach. For information: Frank J. Cozzetto, M.D., c/o All Children's Hospital, Development Department, 801 6th Street South, St. Petersburg 33701.

FAFP 32nd Annual Scientific Assembly, June 17-21, Daytona Hilton, Daytona Beach. For information: Guy T. Selander, M.D., 1736 University Boulevard South, Jacksonville 32216.

Wyeth Autotutors, Florida Academy of Family Physicians 32nd Assembly, June 18-20, Daytona Beach Hilton Hotel, Daytona Beach. For information: Guy T. Selander, M.D., 1736 University Boulevard, S., Jacksonville 32216.

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN[®]

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN[®]/300 mg.

Each time-release capsule contains:

Nicotinic Acid	.....300 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN[®]/250 mg.

Each yellow tablet contains:

Nicotinic Acid	.....250 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN[®]/100 mg.

Each blue tablet contains:

Nicotinic Acid	.....100 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN[®] 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



**When painful spasm
is the presenting
symptom...**

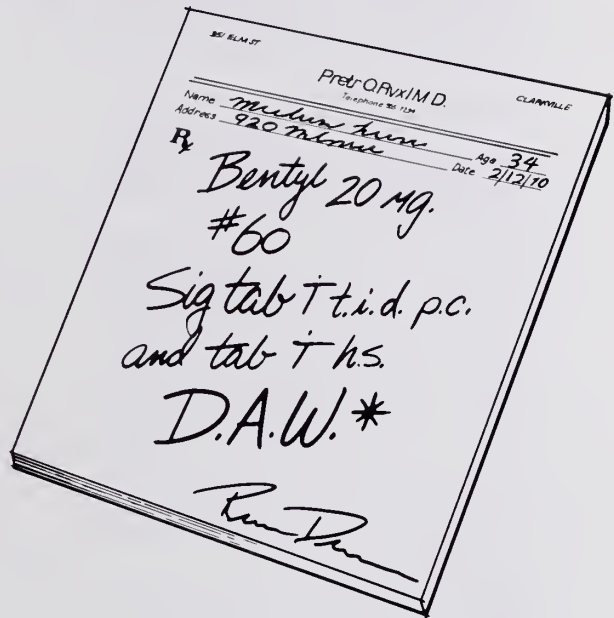


...in the functional bowel/irritable bowel syndrome[†]

be sure to specify

Bentyl[®]
(dicyclomine
hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injectable



**D.A.W.-Dispense as written*

because:

Bentyl passes these tests for product integrity.

- ⊕ The Bentyl molecule is a product of original Merrell research.
- ⊕ At Merrell, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable.
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablets, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Pharmacologic effect in the distal colon compared to placebo^{††} shows how Bentyl affects abnormal motor activity in the irritable colon patient.[†]

[†] This drug has been classified "probably" effective for this indication.

Merrell

^{††} In the experiments that showed significant pharmacologic effect, the dose of Bentyl used was 50 mg. I.M., which is higher than that permitted in the labeling. This dose was deemed justified since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level that occurs after a single 50 mg. I.M. dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy), obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup. *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg. *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACAL COMPANY
Decatur, Illinois 62525 for
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Merrell

0-6546 (Y115C) MNQ 442

The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment



**CONVENTION
PRESS, INC.**

2111 NORTH LIBERTY ST.

**JACKSONVILLE,
FLORIDA 32206**

PHONE 904/354-5555

**Cardiology Associates
and the
Pensacola Educational Program
announce the
Fourth Annual Gulf Coast Cardiology Seminar
entitled**

A Noninvasive Approach to the Cardiac Patient

**March 28-29, 1981
Sheraton Inn, Pensacola Florida**

The Fourth Annual Gulf Coast Cardiology Seminar will be devoted to selected topics relative to current noninvasive procedures used to evaluate the cardiovascular system. The purpose of this seminar is to provide the clinician with a broad overview of various noninvasive approaches to the cardiac patient of the basic cardiac examination including history taking and physical examination and correlation of routine diagnostic studies will be discussed. Advances in nuclear cardiology and echocardiogram will also be reviewed to help the physician who considers such diagnostic studies in his management of cardiac patients.

Selected panels will deal with frequently encountered cardiac problems of the adult patient.

An outstanding faculty has been assembled for this seminar. The format should be of wide interest to all physicians who care for cardiac patients including the cardiologist, internist and family practitioner. A special

session will also be included for the cardiac nurse specialists.

Guest Faculty: Charles Boucher, M.D. from Boston, Massachusetts; Larry P. Elliott, M.D. from Birmingham, Alabama; Henry J. L. Marriott, M.D. from St. Petersburg, Florida; Randolph P. Martin, M.D. from Charlottesville, Virginia; Thorpe Ray, M.D. from New Orleans, Louisiana and Galen S. Wagner, M.D. from Durham, North Carolina.

As an organization accredited for continuing medical education, the Pensacola Educational Program designates this continuing medical activity to meet the criteria for 13 credit hours in Category I of the Physician's Recognition Award of the American Medical Association. This program has been reviewed and is acceptable for 13 prescribed credit hours by the American Academy of Family Practitioners.

Reservation fees: \$100 all physicians; \$30 all paramedical personnel (nurses, technicians, etc.)

Hotel Reservations: Contact The Sheraton Inn, Pensacola, Florida (904) 434-3201

Course Directors: W. H. Langhorne, M.D., C. P. Riley, M.D., Wm. S. Pickens, M.D., and W. Daniel Doty, M.D.

Registration: Make checks payable to:

Cardiology Associates, P.A.
1717 North "E" Street, Suite 503
Pensacola, FL 32501
(904) 434-1093

CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
 Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
 Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
 Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacterio. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age. Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
 †depending on severity



Two convenient dosage forms: 100 mg (white) and 300 mg (peach) Scored Tablets



Tablets imprinted with brand name to assist in tablet identification.



Burroughs Wellcome Co.
 Research Triangle Park
 North Carolina 27709

Control of Human Cancer II

April 4-5, 1981

Fort Lauderdale, Florida

BIOLOGIC CONTROL OF CANCER

HILARY KOPROWSKI, MD, Cloned Antibodies
 JOSEPH SINKOVICS, MD, Chemoimmunotherapy
 KAREL DICKE, MD, Bone Marrow Transplantation
 ROBERT OLDHAM, MD, Biological Modifiers
 CHARLES SCARANTINO, MD, Stem Cell Assay.

TUMORS OF THE HEAD & NECK

ANTOLIN RAVENTOS, MD, Radiotherapy — ALFRED KETCHAM, MD, Surgery
 WILLIAM O. RUSSELL, MD, Pathology

9 AMA Category 1 Physician's Recognition Award Credits.

Registration Fee \$65.00

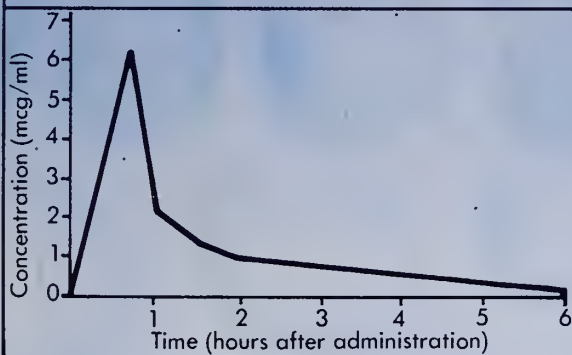
For Information: NORTH RIDGE MEDICAL CENTER
 5757 N. Dixie Hwy., Ft. Lauderdale, FL 33334 • (305) 776-6000

Wyeth Laboratories
 Philadelphia, Pa 19101

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on $T^{90}_{1/2}$ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Wyeth Laboratories • Philadelphia, Pa 19101



Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum


NEW
NAME

Fifty Years Ago

In *The Journal of the Florida Medical Association* for March 1931:

Southeastern Optical Company advertised the Bausch & Lomb Manley Frame, described as "distinctively masculine — appropriate for business, a stag dinner, a golf match" . . . **E. W. Peery, M.D.**, of West Palm Beach published a paper entitled "Some Reasons Why the Oculist Should Do Refractions in Patients with Lowered Vision" . . . At the annual pre-convention meeting of FMA officers and committee members in Jacksonville on February 23, the Scientific Program Committee "very carefully studied the 48 applications for places on the program at the Orlando meeting and selected 22 from this number" . . . Seventh District FMA Councilor **J. Ralson Wells, M.D.**, reported that Brevard County members are "annoyed by the actions and the practices of a non-member physician who, they report, is guilty of renegade practices and twenty-five percent medicine." . . .

And so it was in Florida medicine 50 years ago this month. — E.D.H.



An apple a day won't keep alcoholism away!

The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

Do you have a patient who needs this kind of help? You probably do because the illness is sneaky. For more information and guidelines on how to identify these patients, write to us.

Willingway Hospital

311 JONES MILL ROAD
STATESBORO, GA. 30458

(912) 764-6236

J.C.A.H. ACCREDITED

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

MEDICAL OPHTHALMOLOGIST wanted for busy practice. No refraction or contact lens fitting. Ideal location in East Coast of Florida. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

LOVELY SOUTHWESTERN CLIMATE — multispecialty group seeking OB-GYN physician. Substantial guarantee. Contact Talton Francis, El Paso Medical-Surgical Associates, P.A., 10301 Gateway West, El Paso, Texas 79925.

LOVELY SOUTHWESTERN CLIMATE — multispecialty group seeking anesthesiologist. Substantial guarantee. Contact Talton Francis, El Paso Medical-Surgical Associates, P.A., 10301 Gateway West, El Paso, Texas 79925.

MOORE HAVEN, Glades County (on Lake Okeechobee) — Immediate need for Family Practitioner to live in Moore Haven; population 2,000; hospitals 25 and 45 miles away. Agricultural community with new industry moving in. Health department being only medical facility. Excellent fishing and hunting. Please contact: Walter C. McCants, RPH, P.O. Box 951, Moore Haven, Florida 33471. Phone (813) 946-1212. 9-5:30 p.m.

FLORIDA — Well established East Coast Group seeks fourth Pediatrician. Salary leading to early partnership. Send

C.V. Reply C-1028, Post Office Box 2411, Jacksonville, Florida 32203.

WEST COAST FLORIDA: General Internist (with or without subspecialty). Rapidly growing multispecialty group. New facility, full ancillary services, adjacent ultra-modern hospital. Excellent remuneration and fringe benefits. Send C.V. to C-1031, Post Office Box 2411, Jacksonville, Florida 32203.

INTERNIST — CARDIOLOGIST: Three man practice seeks badly needed associate with immediate availability possible. Excellent opportunity in well established Internal Medicine, non-invasive Cardiology practice in Coral Gables, Florida. Reply C-1036, Post Office Box 2411, Jacksonville, Florida 32203.

GROWING 21-MAN multi-specialty group, with five family physicians, seeking a 6th, board eligible or board certified family physician. Located on the East coast of Florida. Competitive salary and benefits are available. Please send C.V. to C-1029, P.O. Box 2411, Jacksonville, Florida 32203.

WELL TRAINED Family Practitioner or Internist needed to join staff of a Family Medical Center in Jacksonville, Florida. Excellent opportunity for professional and economic growth. Respond with CV to: Susan Masterson, Emergency Medical Services Associates, Inc., 8200 W. Sunrise Boulevard, Building C, Plantation, Florida 33322, or phone (305) 472-6922.

ASSOCIATE DIRECTOR, Division of Geriatric Medicine and Gerontology in approved Family Practice Residency Program — Jacksonville, Florida. Academic appointment — Assistant/Associate Professor — consistent with qualifications, at University of Florida College of Medicine. Duties and responsibilities include teaching of residents and students, curriculum development, research, and administration. Candidates must be Board certified or eligible in appropriate specialty — Internal Medicine, Family Practice, Psychiatry. Excellent salary and fringes. Application recruiting deadline May 1, 1981. Send resume and references to: Dr. Thomas Beach, Dept. of Family Practice, 1824 King Street, Jacksonville, Florida 32204. Equal

Employment Opportunity / Affirmative Action Employer.

THE UNIVERSITY OF FLORIDA, Jacksonville Division, is seeking qualified and experienced candidates for the position of Chairman, Department of Family Practice, and Director of the residency program, located at St. Vincent's Medical Center. The residency is fully accredited and well-established. Students are assigned and there is strong community and staff physician support. The Chairman will provide leadership in the areas of teaching, administration, curriculum management, patient care, and research. Board certification in Family Practice is desirable. Academic appointment at the level of Assistant /Associate Professor, commensurate with qualifications. Excellent salary and fringes. Please forward Curriculum Vitae and references by the recruiting deadline of April 1, 1981 to: Mr. Glenn Flake, Assistant Administrator for Medical Affairs, St. Vincent's Medical Center, P.O. Box 2982, Jacksonville, Florida 32203. Equal Employment/Affirmative Action Employer.

OPHTHALMOLOGIST NEEDED to fill recent vacancy in busy practice designed for 2 physicians. Join Board Certified Ophthalmologist in practice in this friendly Ohio city. General ophthalmology or retina practice. \$75,000 plus fringes first year. Full partnership buy in possible after first year. Respond with CV to C-1043, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED physicians in Family Practice are being sought for staff positions in a developing prepaid health plan in Tampa, Florida. Excellent opportunity to grow with a major national company. Send resume to P.O. Box 24203, Tampa, Florida 33623.

GENERAL SURGEON with Thoracic and Vascular experience, as an associate. General Surgery Board certified. Florida license. Central Florida area with cultural, outdoor, and the many various activities that are desired. Two hospitals supported by several nearby towns. Large flourishing practice. Send C.V. and picture: P.O. Box 298, Leesburg, Florida 32748.

FAMILY PHYSICIAN wanted to step in and take over established Family Practice. Excellent location. Open door and begin active practice. Convenient, helpful terms. I will stay in Jacksonville as full-time faculty with Family Practice Residency. Call collect, Craig Ray, M.D., (904) 737-1848.

ORLANDO — IMMEDIATE Opening. General Practitioner or Emergentian, Forty hour week, no night call. Part-time Orthopedist, Internist, Psychiatrist. Excellent remuneration. Reply: Medical Director, Baywood Clinic, 15645, Farmington Road, Livonia, Michigan 48150.

FULL-TIME CAREER-ORIENTED Emergency Physicians to work in busy Dade County Emergency Departments with an old, established group. Liberal salary with bonus incentives. Send C.V. to: Emergency Physicians, Post Office Box 160429, Miami, Florida 33116.

FAMILY PRACTICE physician sought for full time position in large city hospital with active university affiliated teaching program. Salary negotiable. Florida license required. Please contact S.D. Doff, M.D., Department of Community Medicine and Family Practice, University Hospital of Jacksonville, 655 W. 8th St., Jacksonville, Florida 32209. Phone (904) 358-3272.

ANESTHESIOLOGIST NEEDED, board certified or eligible for 150 bed multi-specialty hospital, private fee-for-service group. Located in Central Florida. Reply with C.V. to LCAA, P.O. Box 1167, Eustis, Florida 32726.

Situations Wanted

PULMONARY INTERNIST, ABIM, University trained all phases of pulmonary medicine, seeks practice position, available July 1981. Reply Clifford Benezra, M.D., 15911 Godwin Court, Fountain Valley, California 92708. (714) 775-0142.

UROLOGIST, 30, American graduate, Board eligible. Excellent training at large New York City Medical Center. Available July 1981. Seeks group practice or partnership. Call (212) 876-5175.

GENERAL, COLON AND RECTUM SURGEON, trained in Colonoscopy,

Board eligible, 35, seeks position in Florida to practice either one specialty or both. Speaks Spanish fluently. Available October 1981. Contact: Luis F. Espallat, M.D., 1517 Texas Avenue, Homestead AFB, Florida 33039. Phone (305) 257-2870.

UROLOGIST seeking position in group or multispecialty practice. Graduate of University of Miami School of Medicine in 1976. Urologic residency experience at U.S.P.H.S. Hospital, Columbia Presbyterian, and Memorial Sloan Kettering in New York City. All areas considered. Available Summer 1981. Curriculum Vitae available. Reply C-1032, Post Office Box 2411, Jacksonville, Florida 32203.

COLORECTAL SURGEON to join group or partnership, available July 1981. Prefer Sarasota/St. Petersburg area. CV on request. Dennis A. Fried, M.D., Department of Colorectal Surgery, Cleveland Clinic.

BOARD CERTIFIED (Family Medicine) Florida license seeks 40 hour a week job in private clinics, public health, or Nursing Homes, also Locum Tenens. Reply: 333 N.E. Surrey Street, Port St. Lucie, Florida 33452. Telephone: (305) 878-8834.

WANTED-PEDIATRIC JOB opportunities anywhere in Florida. Have Florida License. FMG Contact: Dr. Dharmappa, 1700 Mary Court, Apt. 1, Alma, Michigan 48801. Phone (517) 463-2065.

INTERNIST-PULMONOLOGIST, 33, University Hospital trained in Bronchoscopy, I.C.U., P.F.T., Swan-Ganz. Wife physiatrist University trained. Seeking job or practice after July 1981. Reply C-1034, P. O. Box 2411, Jacksonville, Florida 32203.

JOHN L. DRISCOLL, M.D. — General Surgery Resident; CMDNJ/Board Eligible; holds current Florida Medical Licensure; seeking General Surgery practice, group or partnership; available July 1981. Reply: 631 Avenue E, Bayonne, New Jersey 07002.

BOARD INTERNIST, ER Physician with minor orthopedic disability seeks low volume ER, Clinic or administrative position South Florida. All current credentials and insurance. Reply C-1037, P.O. Box 2411, Jacksonville, Florida 32203.

GROUP PRACTICE / Salaried job desired in Florida for a young, Board eligible family physician with 1 year training in pediatrics and 3 years in family practice. Reply C-1038, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST — 29, Board eligible, desires solo practice or partnership from July 1981. Great deal of experience in Critical Care Medicine and Medical Emergency room. Buying the practice may be considered. Please contact: C-1039, P.O. Box 2411, Jacksonville, Florida 32203.

FMG, 33, cooperative; Florida licensed; completing Adult/Pediatric, Allergy/Immunology Fellowship June 1981. Board eligible Pediatrics, Allergy/Immunology. All practice types in Florida considered. Reply C-1040, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED OPHTHALMOLOGIST desires to associate with an Ophthalmologist, part or full time, in Pinellas County or Tampa area. Call (813) 446-2061, week days or (813) 797-3101, evenings; or write, F. Husni, M.D., 1441 Court Street, Clearwater, Florida 33516.

EXPERIENCED BOARD Certified Cardiologist with Florida license seeking opportunity to establish solo practice in Florida. Reply: C-1041, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST — Experienced general pathologist with Florida license desires relocation. Anatomic and clinical pathology boards. Interest in all phases of laboratory medicine. University trained. Strong in tumor pathology. Reply: C-1042, P.O. Box 2411, Jacksonville, Florida 32203.

AMERICAN GRADUATE, University trained. Desires general surgical practice in coastal Florida. Florida licensed. Edward R. Samper, M.D., 2017 N. Goodlet Avenue, Indianapolis, Indiana 46222.

GENERAL PRACTITIONER, Surgical trained, Board certified Abdominal Surgeon. Florida licensed. Seeking relocation, small towns, Florida. Reply: Dr. Krishna, 14556 S. Keystone, Midlothian, Illinois 60445.

OB-GYN BOARD eligible, wants to start private practice in Florida. Reply: M.F.T. Zaim, 150 Palmetto Drive, Shaw

AFB, South Carolina 29152. Phone: (803) 668-3926.

GENERAL SURGEON — 33, Board eligible, seeks solo or hospital based practice. Good references. Reply: A. Gutierrez, M.D., 213 W. New Jersey Ave., Somers Point, New Jersey 08244. Phone (609) 653-1117.

INTERNIST SEEKING immediate practice opportunities in Dade/Broward County. Will consider part-time, E.R., or buying practice. Write: Sailesh M. Dave, M.D., P.O. Box 69-3005, Miami, Florida 33169.

Practices Available

DERMATOLOGY PRACTICE — for sale: fully equipped and furnished, old, well established in Miami. Very easy terms. Phone (305) 753-1293.

MEDICAL OFFICE AVAILABLE APRIL 1981, 475 Biltmore Way, Coral Gables; 1,000 square feet. All furniture, fixtures and equipment ready for sale in-

tact to lessee. Functional, tasteful office, "ready to go" for specialist or generalist or new physician. Call 443-8767 or 665-1713 after 5.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

DURANGO, COLORADO: Magnificent 35 to 40 acre Ranchsites on 2,000 acre ranch. Only a few left. From \$3,000 per acre. Will finance. Incredible hunting on property. Year 'round recreation, fabulous skiing. Russell Yates, Beaver Creek Ranch, P.O. Box 2433, Durango, Colorado 81301. Telephone (303) 259-2680.

ORLANDO: For rent, two offices 1,300 and 2,000 sq. feet in medical building with four other specialists at 6003 Silver Star Road. Excellent location, near

Brookwood Hospital. Telephone (305) 295-4644.

FOR RENT — Bayonet Point Area — Professional office space, new building, ample parking, close to new hospital. Easy access to other hospitals. 2,000 square feet. Will divide. Write or call: Oak Trail Professional Center, 202 Oak Trail Way, Port Richey, Florida 33568. Phone: (813) 863-1553 or (813) 784-1029.

Services

GOLD AND SILVER — Inflation Hedge and only real money. Buy or sell. Contact: Au, M.D. — E.K. House, M.D., 629 West Broad Street, Brooksville, Florida 33512.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Col, 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

When
impotence
is due to androgenic deficiency.

Android 5^{mg} / 10^{mg} / 25^{mg}
Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-pubertal cryptorchidism.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration of excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgenic deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., I. B. Sipahioglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. Drug Therapy, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

Write for new double blind study reprints and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Advertisers

Abbott Laboratories		International Conferences	
Tranxene Seminars	220	Meeting	162
Anderson-Clayton Foods		Janssen Pharmaceuticals	
New Age Sandwich Slices	150	Vermox	156
Bristol Laboratories		Eli Lilly & Company	
Tegopen	216	KeFlex	158
Brown Pharmaceuticals		Merrell-National	
Cerebro-Nicin	222	Bentyl	224
Lipo-Nicin	223	North Ridge General Hospital	
Android	235	Meetings	147, 228
Burroughs Wellcome		Roche Laboratories	
Zyloprim	228	Valium	146
Empirin c Codeine	220a	Bactrim	237
Cardiology Associates		Smith Kline and French	
Meeting	227	Dyazide	162a
Convention Press		Hemocult	220a
Service	226	University of Florida	
Florida Medical Foundation		Meeting	162
Citrus	178	University of Miami	
Florida National Banks		Meeting	157
Service	162	Wetzel	
Geriatric Pharmaceutical Co.		Service	155
Menic	152	Willingway Hospital	
Hedeco		Service	230
Entero-Test	161	Wyeth Laboratories	
		Cyclapen	228

Florida Medical Association Officers and Council Chalmen

Officers

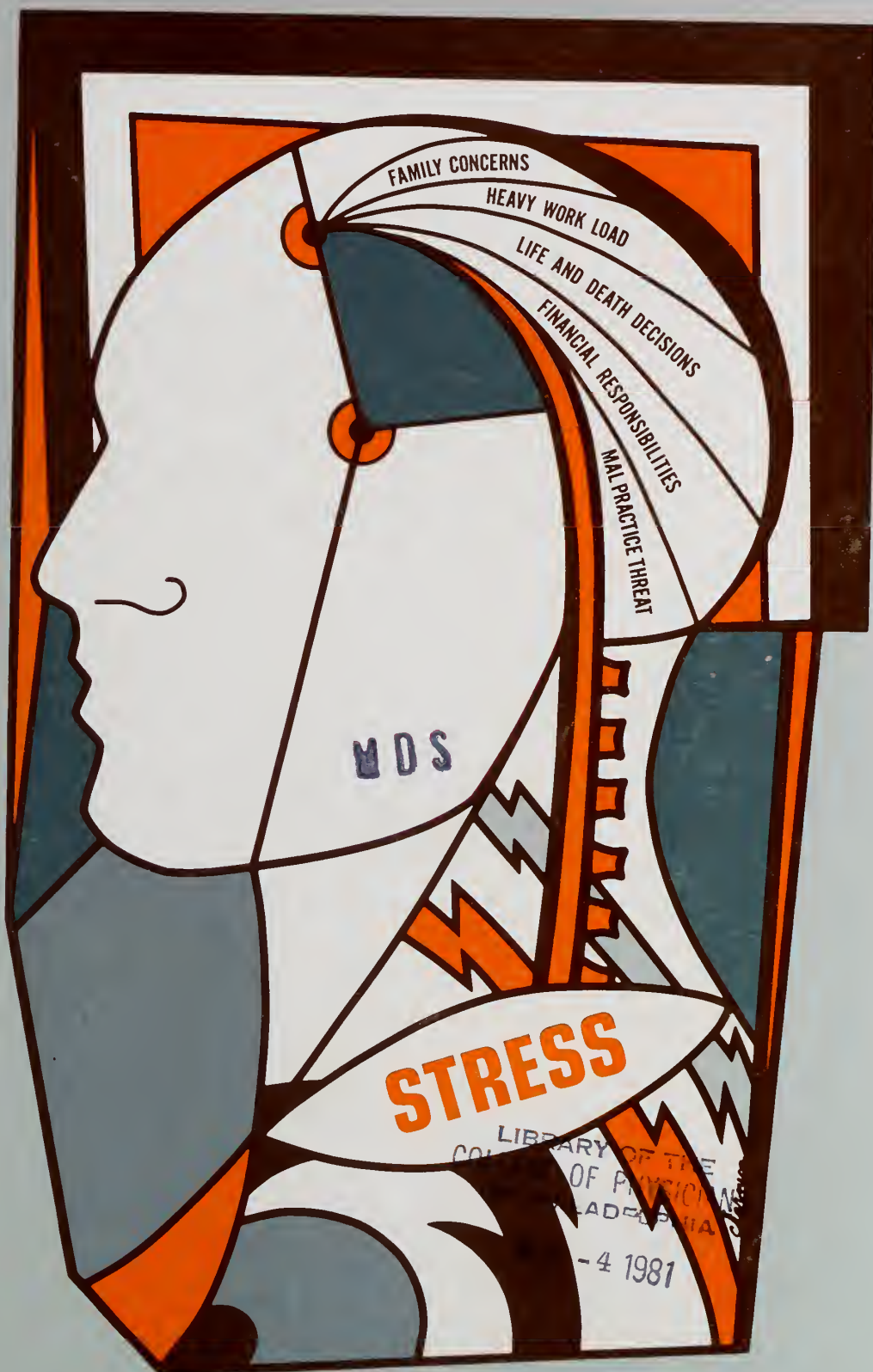
T. Byron Thames, M.D., Orlando, President
Sanford A. Mullen, M.D., Jacksonville, President-Elect
Gerold L. Schlebler, M.D., Gainesville, Vice President
Robert E. Windom, M.D., Sarasota, Secretary
J. Russell Forlaw, M.D., Boynton Beach, Treasurer
Richard S. Hodes, M.D., Tampa, Immediate Past-President
James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation and Regulations
William W. Thompson, M.D., Ft. Walton Beach, Health Care Financing
Joseph T. Ostroski, M.D., Miami, Medical Services
Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
Dick L. Van Eldik, M.D., Lake Worth, Specialty Medicine



APRIL 1981 • VOL 68 • NO. 4



Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to decrease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgeable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

Valium® diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

MICROSURGERY COURSES

The Microsurgery Laboratory at the University of Florida offers three and five day courses aimed at teaching techniques applicable to:

Extracranial to Intracranial Bypass
Digital Reimplantation
Tubal Reanastomosis
Vasovasostomy
Transsphenoidal Surgery
Temporal Bone Dissection
Other Microsurgical Operations

For Information write:

Mrs. Cindy Brady
Microsurgery Laboratory
Box J265
University of Florida Health Center
Gainesville, FL 32610

Saturday, April 11, 1981 - 9:00 a.m.

A Morning With . . .

MERRILL SPENCER, M.D.

**"CEREBROVASCULAR EVALUATION
WITH DOPPLER ULTRASOUND"**

presented by

NORTH RIDGE GENERAL HOSPITAL

and the

CENTER FOR NEUROLOGICAL SERVICES
FORT LAUDERDALE

Dr. Spencer is Director of the INSTITUTE OF APPLIED PHYSIOLOGY AND MEDICINE, Seattle, Washington. His presentation will cover physiological principles, electronic instrumentation, clinical examination and interpretation, management decisions and the future of Doppler.

No Charge

Contact Barbara Chandler for reservations — 776-6000
(Miami - 944-5435)

NORTH RIDGE GENERAL HOSPITAL
5757 North Dixie Highway, Fort Lauderdale, Florida 33334

The P.I.P.E.R. report tells you how well your pension plan is being managed. Which is why you've probably never heard of it.

Only one equity fund manager in Florida is likely to call your attention to P.I.P.E.R.

Southeast Bank.

Because no other Florida bank, insurance company or trust company was evaluated as highly by this well-recognized rating service.

In analyzing the performance of 190 major banks and insurance companies all over the U.S., P.I.P.E.R. (Pension and Investment Performance Evaluation Report) rated Southeast in the top 20%. What's more, P.I.P.E.R.



noted that our rate of return was an outstanding 18.3% over the past two years.

Clearly, Southeast is not only the largest bank in Florida, we are also the best in the State in managing trust assets.

Call us for more information on the P.I.P.E.R. report and additional information on the kind of trust services we provide.



Southeast Bank
You can count on us.®

Member FDIC

Bradenton (813) 748-4262 • Deerfield Beach (305) 421-2200 • Fort Lauderdale (305) 561-7942 • Fort Pierce (305) 464-0050
Jacksonville (904) 358-7752 • Largo (813) 585-8558 • Miami (305) 577-3784 • Naples (813) 261-5225
New Smyrna Beach (904) 428-2401 • Orlando (305) 843-4000 • Riviera Beach (305) 848-7232 • Sarasota (813) 953-8137



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

APRIL 1981 • VOL 68 • NO. 4 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.
E. Charlton Prather, M.D.

Assistant Editors

James K. Conn, M.D.
Lee A. Fischer, M.D.
Edward Pedrero Jr., M.D.
J. Lee Dockery, M.D.
(from Board of Governors)
Francis C. Coleman, M.D.

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Susan L. Milhoan

Consulting Editorial Staff

William A. Alonso, M.D.	Rublin Klein, M.D.
Fuad S. Ashkar, M.D.	Karl J. Kramer, M.D.
Hubert A. Aronson, M.D.	R. G. Lacsamana, M.D.
Thomas D. Bartley, M.D.	Richard F. Lockey, M.D.
Robert L. Batey, M.D.	Philander D. Morgan, M.D.
Pierre J. Bouis Jr., M.D.	George Morris, M.D.
Ms. Deborah B. Wilbur	George A. Neder Jr., M.D.
William T. Branch, M.D.	Richard S. Panush, M.D.
Miguel A. Brito, Jr.	R.A. Penalver, M.D.
Elmer B. Campbell, M.D.	John K. Petrakis, M.D.
Manuel L. Carbonell, M.D.	Phillip B. Phillips, M.D.
Ronald W. Case, M.D.	Michael R. Redmond, M.D.
Louis E. Cimino, M.D.	Albert L. Rhoton, M.D.
Francis C. Coleman, M.D.	James F. Richards Jr., M.D.
Charles Craig, M.D.	Arvey I. Rogers, M.D.
R. Jay Cummings Jr., M.D.	William J. Romanos Jr., M.D.
Raul deVelasco, M.D.	Lees M. Schadel, M.D.
James E. Deming	Frederick W. Schert, M.D.
Pablo Enriquez, M.D.	Guy T. Selander, M.D.
Robert F. Feltman, M.D.	Roberto A. Sosa, M.D.
Richard Feinstein, M.D.	John Stone, M.D.
Lawrence M. Fishman, M.D.	Robert H. Threlkel, M.D.
John W. Glottfelty, M.D.	Benjamin E. Victorica, M.D.
Allan L. Goldman, M.D.	Norman H. Wasserman, M.D.
Henry L. Harrell, M.D.	Thomas M. Wiley, M.D.
Allan Herskowitz, M.D.	Charles D. Williams, M.D.
James T. Howell, M.D.	Governor M. Witt, M.D.
Troy H. Hutchinson, M.D.	Frederic C. Wurtzel, M.D.

Subscription Rate: \$15.00 per year, single copy \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

Symposium on Stress

This issue of *The Journal of the Florida Medical Association* is devoted to the subject of Stress and Lifestyle, which is also the Association's theme for 1980-1981. We are most grateful to the authors and contributors to this issue of *The Journal* for their efforts. (See contents on opposite page).

Special Articles

- 291 Update: FMA-FMF Impaired Physician Program
Guy T. Selander, M.D.
- 293 The Methodist Hospice Program
Clyde M. Collins, M.D.

Editorials

- 247 Stress, Life Style, and the Physician
John E. Adams, M.D.
- 247 The Biological Clock and Longevity
Edward Pedrero Jr., M.D.

Organization

- 301 Sen. Hatch to Speak at Annual Meeting
- 303 Annual Meeting Scientific Program Offers 20 Hours of Free CME Credit
- 311 Restaurants of the Gold Coast
- 313 FMA Annual Meeting Program to Schedule Basic Life Support Certification
- 314 Scientific and Educational Exhibits

Departments

- 245 President's Page
Stress and Lifestyle
T. Byron Thames, M.D.
- 251 Professional Liability Legal Update
- 254a Summary of FMA Board of Governors Meeting
- 255 Gray Paper
- 319 FMA Auxiliary
Citrus, Seafood Sales Aid Impaired Physicians
Mrs. C. Brooks (Ruth) Henderson
- 323 Correspondence
- 326 Book Reviews
- 328 Books Received
- 330 Meetings
- 331 Classified Advertising
- 404 Index to Advertisers
- 404 FMA Officers and Council Chairmen

Cover

Mrs. Dele R. (Toni) Chernesco of Orange Park created the cover for this issue. The theme of Stress is portrayed in geometric expressionism.

Symposium on Stress

Contents

- 261** Is the Medical Marriage Hazardous to Your Health?
Joseph B. Trainer, M.D.
- 265** The Relaxation Response: Your Inborn Capacity to Counteract the Harmful Effects of Stress
Herbert Benson, M.D. and Irene L. Goodale
- 268** The Prevention of Physician Impairment
John-Henry Pfifferling, Ph.D., Jeffrey C. Blum, M.D., and William Wood, M.D.
- 274** Occupational Stress and Productivity: Strategies for Physical and Fiscal Health
Arthur H. Rosen, M.D.
- 281** Are Doctors Different? Reflections on the Psychodynamics of Physicians
Glenn Golloway, M.D.
- 285** System Failure: The Impaired Physician
Everet W. Witzel, M.D., Ph.D.

FROM DIETARY COMPLAINTS



"Too Bland"



"Tasteless"



"No Variety"



"Hard To Cook"



"Only
Cottage Cheese?"



"Daddy's
Dull Diet"

TO COMPLIANCE

INTRODUCING *New Age*TM SANDWICH SLICES

- 90% less cholesterol
- 75% less saturated fat

Now, New Age—a cheese substitute made with vegetable oil—provides the good taste of process cheese without its restrictively high cholesterol content.

New Age has 90% less cholesterol, 75% less saturated fat, yet provides all the protein, vitamins and minerals of process cheese... good news for all health-conscious patients!

AMERICAN
SWISS
SMOKEY
HOT PEPPER



*New Age*TM

is consistent with
the cholesterol-control,
low-fat recommendations
of the third edition of
The American
Heart Association
Cookbook.



President's Page

Stress and Lifestyle

In the past few years much has been written concerning the relationships between the health problems of Americans and their lifestyle. We have all been made aware of overweight, smoking, drinking too much, exercising too little. As physicians we have attempted to educate our patients to changes in their lifestyle which would benefit them medically. As individuals we have considered the same facts as other patients and we, too, have followed the dictates of our conscience where our personal lives are concerned — some of us improving and others making no progress.

More recently, studies and reports have begun to reflect on the problems of health secondary to stress. As our population increases proximity to others because of urban growth produces a greater level of stress; so does unemployment, inflation, fear of draft or war, etc. Most of us accept the role of stress and anxiety and depression states and other emotional problems. Some of us question whether stress plays an important part in the development of hypertension, coronary artery disease, diabetes mellitus, cancer, etc. Much research has taken place in our society on the effects of our lifestyle on health and, more recently, greater emphasis on stress has occurred.

The world has become a more complicated place in which to live. Most of our population no longer works on the land from sunup to sundown six days a week. But the added free time that has come with a predominant 40-hour a week lifestyle has not relieved us of the pressure of daily living. Increased incidences of stress headaches, divorces, suicides, etc. are stark reminders of the tremendous pressures all of us face daily.

Medicine has many challenges today. Cancer, heart disease, strokes, kidney disease, chronic chest disease and a multitude of other problems are being studied vigorously for new solutions. Medicine has also recognized the tremendous effects of stress on health and dedicated physicians are spending countless hours on research into the physical and psychological aspects of this problem and possible answers to make all our lives more rewarding.

Doctors should be interested in the possible health effects of stress on their patients and, equally, on its effects on their own personal health. This issue of the JFMA is directed to the theme of the FMA for 1980-81 — Stress and Lifestyle. Hopefully, it will stimulate each of us to become more knowledgeable about both stress and lifestyle to the benefit of our patients and our families. In addition, I hope it will be added inducement for each of you to attend the 107th Annual Meeting of the FMA April 29-May 3, 1981, at the Diplomat Hotel, in Hollywood, Florida, where further scientific sessions will be held on stress and lifestyle.

Inner peace of mind has been a goal of philosophers throughout the ages. Present day attempts to meet this goal include transcendental meditation, yoga, strong religious beliefs and practices, etc. People frequently attempt to solve their problems with the use of psychotropic drugs, most often unsuccessfully. These drugs may help on a temporary basis but are not long-term solutions. People who successfully deal with stress regularly are generally self-confident and have a personal feeling of self-worth. Each of us must develop our own Shangri-la of the mind where we may go to find peace. Only then can we help our patients to do so.

T. Byron Hammond M.D.

FOR STRESS PATIENTS

(Chronically Ill, Postoperative, Infection, Inadequate Diet, Alcoholism, Surgery, Burns, Fractures, Febrile Illness, G.I. Disorder, Diabetes, Pregnancy and Lactation)

**ON B.I.D. DOSAGE...
ONLY ONE B-COMPLEX WITH C
PROVIDES A SMOOTH,
CONTINUOUS, PREDICTABLE
RATE OF RELEASE THROUGH
MICRO-DIALYSIS DIFFUSION
24 HOURS A DAY**

B-C-BID Capsules

B COMPLEX WITH C

For stress situations, good nutrition or whenever B-Complex with C is indicated...B-C-Bid is better. Its exclusive delivery system (sustained release through micro-dialysis diffusion) provides a smooth, continuous release of essential vitamins which frees your patients from the "peak and valley" effect of ordinary capsules or tablets...without regurgitation or after-taste.

Your patients deserve the predictability that only B-C-Bid can offer. The clinical results suggest that you prescribe it.

EACH B-C-BID CAPSULE CONTAINS:

Vitamin B-1 (Thiamine Mononitrate)	15mg
Vitamin B-2 (Riboflavin)	10mg
Vitamin B-6 (Pyridoxine)	5mg
Niacinamide	50mg
Calcium Pantothenate	10mg
Vitamin C (Ascorbic Acid)	300mg
Vitamin B-12 (Cyanocobalamin)	5mcg

DOSAGE: For continuous 24 hour therapy, one capsule after breakfast and one after supper.



Samples on request.

GERIATRIC PHARMACEUTICAL CORP.
397 JERICHO TURNPIKE, FLORAL PARK, N.Y. 11001



PIONEERS IN GERIATRIC RESEARCH
DEVELOPERS AND SUPPLIERS OF CEVI-BID • GER-O-FOAM • ISO-BID

AVAILABLE ONLY THROUGH THE MEDICAL PROFESSION

Stress, Life Style, and the Physician

It is almost a cliché that we live in an era of "stress." This concept, like its frequent companion, "life style," may appear to lack the precision of the research laboratory, but takes on powerful meaning in the office of every practicing physician. The hypertensive executive who lives beyond his means, the emphysematous patient reeking of tobacco smoke, and the young mother with vague gastrointestinal complaints — these confront us daily.

While the precise physiological mechanisms by which stress impacts upon physical and mental health remain unclear, the importance of internal and external pressures on our well-being has been amply demonstrated and some clues as to the nature of these interactions have begun to emerge. Anthropologic research suggests that we may be biologically poorly adapted to the particular stresses of modern life. It seems likely that our prehistoric ancestors led relatively sedentary lives, punctuated by brief episodes of fight or flight. Biologic response patterns which evolved over millennia to cope with such an existence would be markedly different from those required to deal with the more chronic and unremitting pressures characteristic of our more recently developed modern culture. Striking individual differences in response to stress have been clearly documented, and appear to derive from both inborn and learned factors. Our peripatetic society, and the consequent loss of the extended family, has deprived individuals under stress of a buffer system that was historically of great importance.

Large-scale epidemiologic studies, sampling diver-

gent population groups, have increasingly focused on life style as a major contributor to health and illness. Such factors as diet, smoking, drinking behavior, exercise, and sleep patterns are now seen as important determinants of morbidity and mortality. A recent review estimated that 50 per cent of the premature mortality associated with heart disease and stroke, 37 percent of that associated with cancer, and 70 percent of the increased early death rate due to cirrhosis were linked to life style factors.

Stress and life style impact not only upon our patients but also on ourselves. As medicine has become more complex, more beset by external bureaucracies, sometimes more defensive, and, tragically, occasionally less personal, the physician may feel a decreased ability to act directly in the clinical arena. For those trained in, and committed to, the care of the sick, this is stress indeed. With increased attention to the impaired physician, patterns of stress management and life style appear which are closely correlated with alcohol and drug abuse, and other forms of disability.

This issue of *The Journal* offers a series of contributions by outstanding authorities on matters of stress and life style. It should be most useful to our understanding of our patients and ourselves.

John E. Adams, M.D.
Professor and Chairman
Department of Psychiatry
University of Florida

The Biological Clock and Longevity

How long might most mankind live? The 90th Psalm, a prayer of Moses, records the "The days of our years are threescore years and ten; and if by reason of strength they be fourscore years, yet it is their strength, labour and sorrow."

Life expectancy was reported in 1980 in government statistics to be 73.3 years for people living in the United States. It is amazing how accurate the famous Biblical quote of 70 years of life has been.

The transition from mature adult life to threescore

years and ten for the most part proceeds unmarked and unnoticed. Some scarcely notice the passing of years; others are bent down by them. Centuries ago Hippocrates, the father of medicine, wrote that it was change — especially great change — that was responsible for disease.

Growing old today presents one of the most difficult tasks in human development. Human nature seems to rebel against what appears to be dethronement. Some persons refuse to accept it; others say they cannot entertain the thought of being old.

The basic issue of what part aging per se as opposed to underlying disease plays in effecting intellectual changes in the elderly is becoming more increasingly open to question. Depression, acute confusional states and acute brain syndrome in the aged are all treatable and reversible.

Aging is today being studied by experts in biochemistry, genetics, immunology, microbiology, neurophysiology and endocrinology.

Research centers on three main areas: what processes are responsible for the progressive decline in structure and function of the adult; how the progressive loss of structure and function becomes incompatible with continued life and lead to death; and how the senile state differs from the phenomena of disease.

Behavioral scientists are engaged in theoretical and methodological research in gerontology and especially of the elderly's personality and accommodation to change.

The latter period of adult life is like earlier ones, a time of change and transition. It is often characterized by physical decline and a decrease in energy, but it also can be a time of psychological growth.

Behavioral scientists claim that during the latter part of adult life, attitudes, aspirations and one's concept of self are sensitive and vulnerable to many stimuli. It is the time when motivation is high for change toward new behaviors. It is at this point that the elderly person's potential is flexible and when society can provide a truly humanitarian environment for the aged. It is at this point when physicians allying science, experience, compassion and common sense can restore to the old their sense of their own value. It is at this point where physicians can slow the biological clock of premature aging.

How can one face the crises of aging in a positive fashion? First, by accepting the fact that aging is something positive, not something simply to be endured. By

realizing that aging is not a process that inevitably affects all individuals equally. The list of older persons with significant accomplishments is long. Picasso continued his prodigious output until his death at 92. Titian worked at his easel until the plague struck him down at 99. Grandma Moses became a painter at 76 and finished her last canvas shortly before her death at 101. Leopold Stokowski was still conducting when he died at 95 years of age. George Burns at 85 still entertains successfully.

The aged person often looks upon death as a deliverance, as the end of his afflictions, as repose in God, like a haven in which he can take shelter from all vicissitudes of life. The physician should help his aged patient accept the prospect of death with serenity.

Some known aids in slowing the biological clock and increasing longevity are good nutrition, consistent exercise, refraining from smoking and avoiding overweight.

Physicians should not only use all the resources of scientific medicine but should also help teach people to live better, to recognize and correct the faults in their lives early.

Old age is a natural phase of our human life that stands in its own right, just as the other human life — phases of infancy, childhood, youth and adulthood. Old age deserves its own dignity, its own privileges and character.

One can reject old age by bitterness, cowardice and complaint or accept it with thanksgiving, faith, hope and love. Old age requires courage, the courage to make the complete and final offering of our lives.

Physicians and patients must accept aging as a new phase and new style of life and seek to discover the values and the precious opportunities available to make it worthwhile and fulfilling.

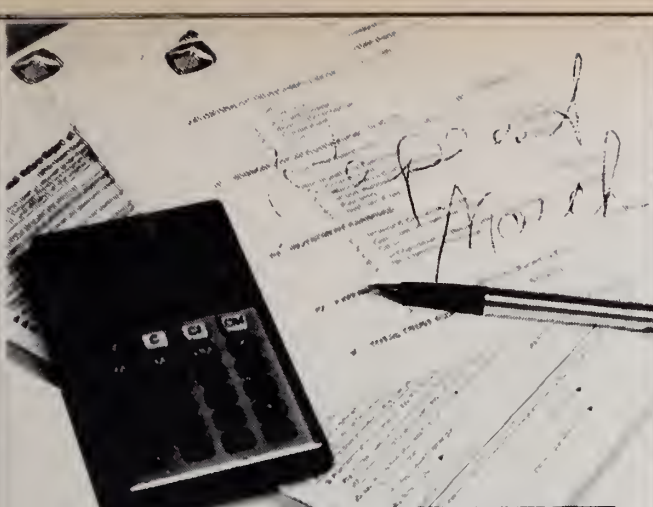
The fountain of perpetual youth, longevity and eternal life in a physical body has not been discovered.

As researchers in all branches of the medical sciences continue efforts to unravel the mystery of aging and to slow the biological clock, it is appropriate to remember the words of Robert Browning:

*Grow old along with me
The best is yet to be!*

*Edward Pedrero Jr., M.D.
Assistant Editor
Tampa*





PROFIT FROM OUR EXPERIENCE

For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

We specialize in attaining the results that you require from your account in the areas of:

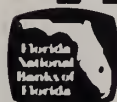
- **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.

- **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.

- **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

PEOPLE WHO KNOW HOW.



Florida National Trust Services

214 Hogan Street
Jacksonville, Florida 32231
Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC

THE HOT SUN, A COOL BREEZE AND FLORIDA SEAFOOD

What finer combination? Right now is the time to order Florida's Finest Seafood, fresh from the Atlantic and Gulf, to you or your friends.

This seafood is Flash Frozen to ensure freshness, and ready for immediate cooking and serving.

Lobster Thermidor, Florida Lobster, Stone Crab Claws, Shore Dinners, Pompano Papillote, Swordfish Steaks — all of these delectable treats await you for the asking.

And for the first time — **Jumbo Shrimp!** These spectacular Jumbo Shrimp are peeled and deveined, ready for cooking and eating . . . wait til you hear the raves from your family and friends. These beauties are over 4" long, and the taste is mouth-watering! (3# — \$49.75; 6# — \$79.75, plus delivery). This is **pure shrimp — no shells — 100% edible** — ready to boil, steam or fry.

REMEMBER — these Florida Delicacies are available all year long — **there is no season without seafood.**

Healthful, Delicious and Low Calorie! The Perfect Combination! Surprise your family and friends with **FLORIDA'S FINEST SEAFOOD.**

Use the handy order form below, or contact your local Chairman or President, or write:

Mrs. C. Brooks Henderson
Florida Medical Association Auxiliary
1610 S.E. 22nd Avenue
Ocala, Florida 32670
(904) 629-1211

Benefits go to the Florida Medical Foundation . . .

All orders arrive in our own styrofoam container, which can be used again and again. All products are unconditionally guaranteed.

Name: _____

Address: _____

Phone No.: _____

Item Ordered: _____

Brochure Requested ☐

SPECIFY
ZYLOPRIM[®]
(allopurinol)
THE
ORIGINAL
ALLOPURINOL



Two convenient dosage forms:
100 mg (white) and 300 mg (peach)
Scored Tablets



Tablets imprinted with brand name to
assist in tablet identification.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



Professional Liability Legal Update

Medical Records

In virtually every discussion of medical malpractice risk management, the critical importance of keeping accurate, complete medical records is stressed. Yet, in spite of these constant admonitions, large numbers of physicians continue to be perilously lax in their record keeping procedures. Because of recent legislative changes, the need for maintenance of proper medical records must once again be emphasized.

The 1979 Medical Practice Act now provides that a physician may be subjected to disciplinary action for failure to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient history, examination results and test results. The disciplinary action may include suspension or revocation of the offending physician's license, as well as the imposition of an administrative fine of up to \$1,000 for each separate offense.

The necessity for good medical records should be obvious to all physicians. The volume of patients and the length of time between their visits, makes good records essential to continuing care and treatment of patients. In addition, however, it must be realized that the need for good record keeping has become greater in the face of the increase in frequency and severity of malpractice claims. In the unfortunate event that a lawsuit is commenced, good records can be a physician's best ally. Indeed, in most cases they form the bedrock of the defense.

In evaluating a potential malpractice claim, one of the first steps taken by a plaintiff's attorney is a thorough review of the medical records. Many times good medical records prevent the case from ever going beyond this stage. Obviously, if the records indicate that the course of treatment given the patient was justified or that the result complained of was merely a risk inherent in the procedure performed, the chances of a plaintiff's attorney actively pursuing the claim are slight. On the other hand, incomplete or inaccurate records may not only precipitate a lawsuit that might have been avoided, but will often contribute significantly to a successful verdict for the patient.

If in preparing medical records you keep several basic points in mind, you can greatly improve the quality

of your records and substantially reduce the possibility that these records will be unjustifiably utilized against you in litigation. First, all medical entries should be made promptly and in a clear and legible fashion. The longer you wait, the greater the chance for error. Secondly, you should constantly strive to maintain the proper information in your records. A good rule of thumb is that the records should contain whatever you, as a consultant or subsequent treating physician, would need to acquire an understanding of the patient's history and effectively commence treatment. Likewise, in a case in which you deviate from the usual course of treatment it is always helpful if you record the reasons for your deviation. When ordering tests for hospital patients insure that the test results have been recorded in the patient's chart and reviewed prior to the surgery. This is true even though the "pre-op tests" are considered "routine". When medical "trouble situations" develop a physician should document the crisis carefully and as thoroughly as possible. Note the efforts, the diligence and alternatives considered. Note the fact a consultant was called and the action taken, etc.

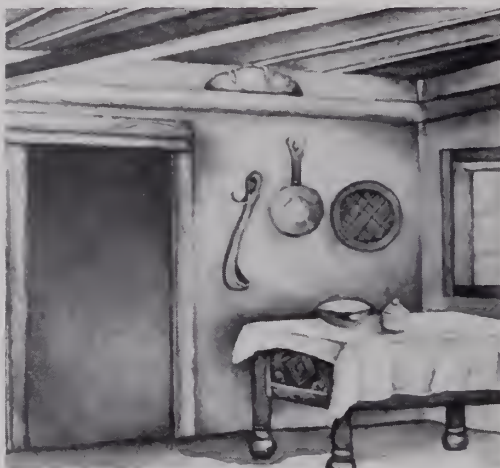
As important as what medical records should contain is what they should not contain. The guiding principle is relevancy. You should guard against inclusion of unnecessary or gratuitous comments. For example, irrelevant personal observations about the patient's personality should be avoided. Likewise, the records should not be used to criticize other physicians or hospitals. And, most importantly, physicians should not record unwarranted admissions of liability in cases in which an adverse medical result is achieved.

No matter how careful you are in your record keeping, there will invariably be times when you discover that an inaccurate entry has been recorded. In this case, you should be extremely careful in correcting the inaccuracy to avoid even the slightest implication that the records have been tampered with. The best way to correct the error is simply by drawing a single line through the inaccurate original entry. An initialed marginal note should also be made indicating the error and including the time and date of the corrected entry. It is far better for the record to show that a record-keeping effort has been made and corrected than to allow the suggestion that the records have been "doctored". In a malpractice action, once the suggestion of record tampering is successfully made, the physician's credibility is almost always injured beyond repair. This destruction of the physician's credibility leads most often not only to a successful verdict for the patient, but also to a verdict far in excess of what would have been awarded absent evidence of altered records.

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Fla.

Yesterday's Folk Remedy:

A rye loaf in the rafters.



Early in this century in Central Europe, almost every farm family kept a loaf of moldy rye bread on one of the kitchen beams. When any family member was cut or bruised, it was an old custom to cut a thin slice from the outside of the loaf, mix it into a paste with water, and apply it to the wound with a bandage. It was believed that no infection would then result from the cut.¹



Today's Tradition: **Tegopen**[®] (cloxacillin sodium)

for the treatment* of
known or suspected
staphylococcal
infections such as:

- Acute sinusitis
- Furunculosis and carbuncles
- Impetigo
- Secondarily infected dermatitis
- Cellulitis
- Abscesses
- Infected sebaceous cysts

In serious, deep-seated
staph infections, 500 mg
q.i.d. dosage is
recommended.[†]

- Tegopen has been reported active against 96% of *Staphylococcus aureus*.²
- 80% of *S aureus* has been reported resistant to amoxicillin and ampicillin.[‡]
- 88% of *S aureus* has been reported resistant to penicillins G and V.[‡]
- Staph resistance to erythromycin may develop during a course of therapy.³



Available as 500-mg and 250-mg capsules
and Oral Solution 125 mg/5 ml.

Tegopen[®] (cloxacillin sodium) Today's Penicillin for Today's Physician

1. Florey HW, Chain E, Heatley NG, et al: *Antibiotics*. London, Oxford University Press, 1949, p 2.
2. Bac-Data Bacteriologic Report, Professional Market Research, 1978-1979. The clinical significance of *in vitro* data is unknown.
3. Erythromycin prescribing information (in *Physicians' Desk Reference*, ed 34. Oradell, NJ, Medical Economics Co, 1980) states that staph resistance may develop during treatment.

See brief summary of prescribing information on
an adjoining page.

Copyright © 1981, Bristol Laboratories

*Note: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin.

†In serious, life-threatening infections, oral preparations of the penicillinase-resistant penicillins should not be relied on for initial therapy.

‡Not all isolates may have been tested using both discs.

Tegopen®

(cloxacillin sodium)

Capsules and Oral Solution

Brief Summary of Prescribing Information

For complete information, consult Official Package Circular
(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q 6h.

Children: 50 mg./Kg./day in equally divided doses q 6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®

Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201



THE COMPLETE INVESTMENT PORTFOLIO INCLUDES RARE COINS.

Rare coins can be an extremely rewarding way to diversify your investment portfolio. Quality U.S. rare coins provide a stable inflation hedge and have appreciated over the last decade at a rate averaging over 57% annually. Coin investing is the smart, sophisticated, and highly profitable way to complete your investment portfolio.

If you've been considering rare coins, you need professional guidance and expert advice. We are one of the largest firms in the country specializing in quality United States Rare Coins. We can also assist you in establishing coin funded Keogh, IRA, or Corporate Retirement Plans.

Serious inquiries invited.

(305) 373-3001

By appointment only.



**NUMISMATIC
INVESTMENTS
OF FLORIDA**

Brickell Center, Suite 701
799 Brickell Plaza
Miami, Florida 33131

Members:

Professional Numismatists Guild
& American Numismatic Association

Board of Governors

OF THE

FLORIDA MEDICAL ASSOCIATION

P. O. BOX 2411 - JACKSONVILLE, FLORIDA 32203

W. HAROLD PARHAM, D.H.A., Executive Vice President

*T. BYRON THAMES, M.D., President
*SANFORD A. MULLEN, M.D., Pres.-Elect
*GEROLD L. SCHIEBLER, M.D., Vice President
*ROBERT E. WINDOM, M.D., Secy.
*J. RUSSELL FORLAW, M.D., Treas.
O. WILLIAM DAVENPORT, M.D., PP-81
*RICHARD S. HODES, PP-82
JOSEPH C. VON THRON, M.D., AMA Del.-81

JAMES F. RICHARDS, M.D., AL-81
*J. LEE DOCKERY, M.D., A-82
THOMAS E. McKELL, M.D., B-83
JAMES C. WHITE, M.D., C-81
NORMAN KENYON, M.D., D-84
JAMES B. PERRY, M.D., Speaker
VERNON B. ASTLER, M.D., FPIR-81
EUGENE C. PEEK, JR., M.D., FDHRS-81
BENJAMIN M. COLE, M.D., SBME-81

*Executive Committee

DONALD C. JONES, Executive Director

Summary of the FMA Board of Governors Meeting March 14, 1981

The following is a summary of the major actions taken by the Board of Governors at its meeting January 14, 1981 at the Host International Hotel Tampa, Florida.

THE BOARD:

1981 Annual Meeting

Approved an amendment to the Annual Meeting format to change the starting time for the Auxiliary/FLAMPAC luncheon on Friday, May 1st from 12:15 to 12:30 p.m., due to a special presentation to be made in conjunction with the President's Baldwin Lecture during the General Session which will extend this session.

Noted that a special Annual Meeting "Flyer" will be sent to all FMA members in the immediate future, outlining all the activities to be held in conjunction with the Annual Meeting, including:

- Meetings of the House of Delegates and Reference Committees.
- Scientific Program and Specialty Group activities.
- President's Country and Western Cookout.
- FMA Auxiliary/FLAMPAC activities.
- The FMA 5,000 meter Health Run.
- Blue Shield Informational Meeting.

1982 Annual Meeting Location

After careful deliberation, the Board approved a recommendation that the 1982 Annual Meeting be held at the Diplomat in lieu of the Sheraton Twin Towers in Orlando as previously approved by the Board. This action was taken in the best interests of the membership to insure that the facilities selected for the Annual Meeting are adequate to serve the many diversified meeting requirements of the FMA, its county medical societies and related organizations who participate in the Annual Meeting. The Board reaffirmed the desire expressed by the House of Delegates to

secure, at the earliest possible date, alternate locations for the Annual Meeting in the Central Florida area.

Specialty Screens

Reaffirmed the current FMA position of opposition to the application of Specialty Screens (Dual Fee Schedules) in Florida and also reaffirmed the Board's previous action that FMA, if invited, participate in the defense of the lawsuit filed by the Dade County Society of Internal Medicine against Blue Cross and Blue Shield of Florida, GHI and the Department of H.H.S., and that FMA's participation would be for the purpose of defending the position which has been adopted and reaffirmed by the FMA House of Delegates in opposition to specialty screens.

Optometrists Lawsuit Re: Drug Prescribing

Authorized the FMA to actively support the position of the Florida Society of Ophthalmologists in the lawsuit filed by the Florida Optometric Association against the Florida Department of Professional Regulations and the Board of Pharmacy regarding the prescribing and use of non-controlled drugs and that FMA seek to intervene in the lawsuit and to authorize FMA Legal Counsel to assist the Ophthalmologists and the Board of Medical Examiners in the preparation and presentation of necessary testimony and legal arguments in opposition to the position of the Florida Optometric Association and that the use of outside legal counsel be authorized as necessary, and further that Mrs. Nancy Wittenberg, Secretary to the Department of Professional Regulations, be provided with a summary of FMA's position regarding this issue.

Contingency Fees

Approved a recommendation to the House of Delegates that FMA explore in every feasible manner a resolution to the issue of contingency fee contracts.

Florida Relative Value Studies Update

Reaffirmed current Association policy that the RVS is intended solely for the purpose of aiding and determining relativity for physician services only and requested that the Committee on RVS, in carrying out its functions in updating the 1975 RVS, submit all questions and recommendations which may arise regarding modifiers to the FMA Executive Committee for a determination of policy.

PMUR Contract

Received, as information, a report that an agreement had been reached with Blue Cross and Blue Shield to continue peer review activities in Florida with the exception of Dade and Monroe Counties. Group Health, Inc., of Miami has indicated that it would not renew the contract with the Foundation to continue peer review in these counties.

COUNCIL AND COMMITTEE REPORTS

Reviewed the Report and Recommendations of FMA Councils and Committees and took the following actions:

AD HOC COMMITTEE ON FINANCE

FMA Dues

Based upon the previous actions of the Executive Committee, Board of Governors, House of Delegates and the Executive staff in streamlining and greatly increasing efficiency of the Association and the acute inflationary factor in the economy affecting everyone, the Board concurred in the Committee's recommendation that the House of Delegates approve an increase in dues for the FMA in the amount of \$50 (\$175 to \$225), to be effective January 1, 1982, and further that the Board recommend to the House annually whether an increase in dues is necessary to carry out the proper functions of the Association.

The Board also directed that the interest income from the mortgage payments received as a result of the sale of the property at 801 Riverside Avenue be utilized for operating expenses and that the principal payments of \$100,000 per year for 10 years be placed in the Reserve Trust Fund which should help to insure the financial stability of the Association for the foreseeable future.

RESERVE TRUST FUND COMMITTEE

Reviewed the Report and Recommendations of the Committee in keeping with the actions of the House of Delegates last May in approving the establishment of a special Trust Fund for current and future reserves of the Association.

- Approved selection of the Southeast Bank Trust Company as the Trustee for the fund and authorized continued use of the money fund of the Southeast Bank as long as deemed feasible.
- Authorized the FMA Executive Vice President to serve as agent for this Committee to conduct necessary transactions on behalf of the Committee.

JUDICIAL COUNCIL

Physician Charges for Laboratory Services

Received, as information, the opinion rendered by the Judicial Council that physicians using medical laboratories should charge the patient exactly what the laboratory charges a physician, provided the physician may charge, in addition to the above, a reasonable charge for the acquisition of the sample and a reasonable handling charge.

Voted to reaffirm and submit to the House of Delegates the action taken by the Board regarding laboratory services in January 1970:

1. That it is preferable that the laboratory, not the attending physician, bill and collect from the patient or third party payor for laboratory services. Where circumstances make this impractical or where increased costs to the patient would result, the bill submitted by the attending physician to his patient or third party payor should state the name of the laboratory performing the services for his patient and the exact amount of the charge paid or to be paid by the physician to the laboratory. Medical societies are urged to use all means legally available to them in effectuating the foregoing.
2. The attending physician is entitled to fair compensation for the professional services he renders. He is not engaged in a commercial enterprise, however, and any markup, commission, or profit on the services rendered by a laboratory is exploitation of the patient.
3. In billing patients for laboratory services which attending physicians perform for their own patients, the bill should provide information to show where such services were performed, as well as an adequate description of the services provided and the specific charges made.

COUNCIL ON MEDICAL SERVICES

Governor's Council on Drug Abuse

Recommended to Governor Graham that consideration be given to re-establishing the Council on Drug Abuse.

lishing the Governor's former Council on Drug Abuse. It was noted that with the reorganization of DHRS the Council had been transferred to the Mental Health office and has since not been able to obtain priority status, funding or the visibility necessary to conduct an effective program.

Administrative Medicine Committee

Concurred in the Council's recommendation that the FMA Administrative Medicine Committee be dissolved, as alternative effective communications and liaison already exists through other mechanisms with the organizations served by the Committee.

COUNCIL ON SCIENTIFIC ACTIVITIES

Annual Meeting Scientific Program

Received a report on the Scientific Program for the 1981 Annual Meeting which will follow the general theme "Stress and Lifestyle" as requested by FMA President, Dr. Thames. The complete program will be published in the April issue of *The FMA Journal*, as well as the special Annual Meeting Flyer.

AMA Symposium on Diet and Exercise

Approved FMA co-sponsorship for the AMA's "Symposium on Diet and Exercise: Synergism in Health Maintenance" which is scheduled to be held at Lake Buena Vista, Florida, November 3-4, 1981.

COUNCIL ON HEALTH CARE FINANCING

Workers' Compensation

Expressed support for legislation which would remove the requirement for a sworn statement under penalty or perjury to be appended or stamped on every Workers' Compensation claim form.

James F. Richards, Jr., M.D.

Commended Dr. James F. Richards, Jr., for his many years of work and effort expended on behalf of the members of the Florida Medical Association in seeking improvements in Florida's Workers' Compensation program, including equitable allowance for physicians' services.

Medicaid - Promotion of HMO's

Voted to express to the Secretary of the U.S. Department of Health and Human Services, the Governor of Florida, and the Secretary of the Department of HRS opposition to any Medicaid funds needed for patient care being used by HMO's/PHP's for the purpose of marketing their programs to Medicaid eligibles.

Government Subsidies for Medical Delivery Programs

Expressed opposition to any form of government subsidy for medical delivery programs such as HMO's and PHP's to the exclusion of other medical care delivery programs or systems.

HMO'S

Preventive Health Education Program for New Mothers

Approved the recommendation to utilize the AMA study on HMO's as amended by the AMA House of Delegates in reviewing and monitoring HMO's in Florida and that FMA component county medical societies be requested to monitor HMO activity in their area and report any information or concerns to the FMA Council on Health Care Financing.

COUNCIL ON SPECIALTY MEDICINE

Endorsed the Department of HRS new preventive health education program for new mothers.

COUNCIL ON LEGISLATION

Finalized the FMA position on a number of issues affecting health, to be addressed during the 1981 Session of the Florida Legislature.

Medical Practice Act

Approved the category of "sponsor" of amendments to the Medical Practice Act that would provide for:

- A. Guidelines for development and approval of protocols with Advanced Registered Nurse Practitioners to include filing of approved protocols with the State Board of Medical Examiners.
- B. Criteria for physician supervision for ARNP's operating in accordance with such protocols.
- C. Restriction to a maximum of two the number of ARNP's that one physician can supervise.
- D. Requirement that a physician must practice in the same community as the ARNP supervised.

Approved a position of "endorse" for:

- Increased funding for county health units in the amount of \$10,900,000.
- Temporary licensure of public health physicians.
- Increased funding in the amount of \$30,500,000 for physician services in Medicaid.
- Increased funding for salaries of state-employed physicians.
- Amendments to school health physical law to allow schools to carry out examination and screening unless parent requests exemption (SB 178, HB 197).

- Changes to Department of Professional Regulation Statute relating to selection of investigators, approval of budgets by Board, and handling of complaints.

Adopted a position of "opposition" to legislation that would provide for:

- Subsidy for state employees enrolling in HMO's.
- Rewrite of Physical Therapy Act which includes a redefinition of "Physical Therapy" and elimination of requirement for physician's prescription for services.
- Mandated use of problem-oriented medical records (SB 106).
- Elimination of current criteria for issuance of temporary and limited medical licenses (SB 182).
- State takeover of county health units and development of primary care programs in county health units (SB 162).
- Authorization for optometrists to use and prescribe drugs.

- Licensure of Homeopathic physicians (HB 49).

- Hospital privileges for chiropractors (HB 242).

- Funding for HSA's and the SHCC.

- Expansion of Wrongful Death Act (SB 150, HB 104).

- Freedom of choice in selection of physicians.

- School of Chiropractic.

Adopted a position of "disapprove" to legislation for:

- Funding for School of Optometry.

- Licensure of Lay Midwives.

- Itemized billing for hospital services (SB 186).

- Mandate for HMO's to include chiropractic services (Exempts IPA's) (HB 120).

FMA

gray paper



735 RIVERSIDE AVENUE / BOX 2411 / JACKSONVILLE, FLORIDA 32203 / (904) 356-1571

W. HAROLD PARHAM, D.H.A., EXEC. VICE PRES. / DONALD C. JONES, EXEC. DIRECTOR

(Editor's Note: This is an abbreviated version of FMA Gray Paper #81-1, which was mailed in March to county medical society officers and others).

ERRONEOUS INFORMATION CONCERNING MEDICAID'S ABORTION POLICY was published in the December 23, 1980 issue of *The FMA Briefs* based upon a communication from the Department of HRS. The following clarification has been received. On October 1, 1980, the time limit for reporting a pregnancy as a result of incest was eliminated. The only requirement is a statement by the physician that he/she was informed that the pregnancy resulted from incest. The physician does not have to identify the informant. There is still a time limit for reporting a pregnancy from the result of rape. It has been changed from 60 days to 72 hours. Prior to these changes, abortions were performed only on the basis of medical necessity.

SPECIALTY SCREENING SYSTEMS TO DETERMINE CHARGES AND ALLOWABLE FEES for physicians caring for Medicare patients is illegal, U.S. District Court Judge Horace W. Gilmore has ruled in Michigan. All physicians, including non-board certified family physicians, must be covered by a single screen, separate from those for chiropractors, podiatrists and dentists. The mandatory injunction was issued as a result of a suit by the Michigan Academy of Family Physicians against the Department of HHS, and Michigan Blue Cross/Blue Shield, the state's Medicare carrier.

THE FMA AUXILIARY'S "DAY IN THE LEGISLATURE" PROGRAM will be held April 15-16 in Tallahassee. A number of rooms have been reserved for both Wednesday night, April 15, and Thursday night, April 16, at the Duval Hotel, 415 N. Monroe St., Tallahassee, Florida 32302; (904) 224-2727. The deadline for reservations is March 14, and should be made directly with the hotel. The Tallahassee Hilton will be the site of all meetings, meals, and workshops. Registration begins on Wednesday, 11:00 a.m. at the Hilton. The program is designed for FMAA Legislative Committee Chairmen, FMA Legislative Chairmen, Key Contact Physicians, FLAMPAC Chairmen, and all others who are interested. For more information on the program, contact Mrs. James (Beebe) White, State Legislation Chairman, 344 John Anderson Drive, Ormond Beach, Florida 32074; (904) 677-5097.

EDWARD R. ANNIS, M.D., AND LUIS M. PEREZ, M.D., were honored by the American Medical Association National Awards Program for Medical Speakers. Dr. Annis, of Miami Shores, won the Silver Award for a presentation on medicine and government as a television talk show guest. He is a Past President of AMA and is Chairman of the FMA Speakers Bureau. Dr. Perez, of Sanford, won the Bronze Award as host for a television talk show. Past honors for him include receiving the Benjamin Rush Award for citizenship and community work, and FMA's A. H. Robins Award for Outstanding Community Service by a Physician.

SEARCH WARRANTS TO OBTAIN PHYSICIAN RECORDS have been restricted as a result of a new federal law, (PL 96-440). According to guidelines issued by the U.S. Justice Department, federal law enforcement officers may not seek a warrant to obtain a physician's records unless there is considerable jeopardy that the records will be lost or destroyed otherwise, or unless a criminal act is suspected.

FLORIDA'S HOSPITALS MET THEIR 1979 AND 1978 VOLUNTARY COST CONTAINMENT GOALS in reducing the rate of increase in hospital expenses, according to the Florida Committee on the Cost of Medical Care and the state's Hospital Cost Containment Board annual report to the Legislature. The rate of increase in hospital expenses, when adjusted for prices and utilization, was reduced from 17.7 percent in 1977, to 13.6 percent in 1979. The committee is a coalition of hospitals, physicians, insurance companies, Blue Cross/Blue Shield and others to reduce the rate of health care costs voluntarily without further government controls.

A COPY OF THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE (GMENAC) Report has been forwarded to the president of each FMA recognized specialty group at the request of FMA's Council on Specialty Medicine. The FMA Board of Governors has also authorized that a copy of this report be provided to any county medical society that requests one. The GMENAC report which is undergoing close review by FMA Councils and Committees, identifies surpluses and shortages for various medical specialties and could have a major impact on the allocation of medical education funds. County medical societies can order single copies by writing to the Medical Services Department at the FMA headquarters office in Jacksonville.

PHYSICIANS, CLINICS OR ANY OTHER ENTITIES seeking major medical equipment are required by 381.494 (k) of the Florida Statutes to give the Department of Health and Rehabilitative Services at least thirty days notice prior to such an acquisition. The notice requirement permits a determination of whether or not the major medical equipment is subject to certificate-of-need review. This notification applies to physicians who may purchase a piece of major equipment for their offices. Major medical equipment that is not purchased by health care facilities and does not provide services to hospital inpatients is not subject to certificate-of-need review. However, the thirty-day notice to HRS prior to acquisition of any major equipment is still required. Major medical equipment is defined as any medical equipment costing \$150,000 or more. Copies of the one-page notification form and any inquiries may be addressed to Nat Ward, Office of Community Medical Facilities, DHRS, Building 2, Room 220, 1317 Winewood Boulevard, Tallahassee, Florida 32301; (904) 488-8673.

IN RESPONSE TO FMA'S SUCCESSFUL LAWSUIT against HHS, formerly HEW, prohibiting the disclosure of Medicare fee payments made to physicians, the Department of HHS has announced a "policy action" on the issue and published same in the Federal Register. The suit was brought to enjoin HEW permanently from publishing a list which identifies by name every physician in the U.S. who treated Medicare beneficiaries in 1977, and states the amount of income he or she received from that program in 1977. Judge Charles Scott presiding for the federal district court for the middle district of Florida in Jacksonville found on behalf of FMA in 1979 and said in part such action would "constitute a clearly unwarranted invasion of privacy and is prohibited by the privacy act from disclosure without the prior written consent of each affected individual." Excerpts from the policy statement of interest to Florida physicians are as follows: "The Department's disclosure of the amounts of payments to individual physicians under the Medicare program has been contested in Federal Court in the cases of Florida Medical Association, Inc., et al. v. Department of Health, Education, and Welfare, et al. Both courts have concluded that the disclosures do constitute an unwarranted invasion of personal privacy of the individual physicians and the Secretary has been enjoined from disclosing the amounts of payment to individual physicians. The Secretary has considered the competing interests and has concluded that the public interest in the individually identified payment amounts is not sufficient to compel disclosure in view of the privacy interests of the physicians found compelling by the courts."

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

APRIL 1981
VOL 68 • NO. 4

Symposium on Stress

Is The Medical Marriage Hazardous To Your Health?

Joseph B. Trainer, M.D.

"Dr. and Mrs. Gerald Feiser have the honor of announcing the marriage of their daughter Lanette to Dr. John Roger Vermeer, Resident Physician in General Surgery at Inglenook Community Hospital on Saturday, March the twenty-eighth." The details are added, but the scenario is set. Presumably the principals are delighted, if frightened at their new prospects, the relatives likewise, and the friends of the bride regard it as a triumph in the lottery of life that Lanette is about to acquire a real doctor for a life-time partner.

The usual fact is, none of the above has arrived at his opinions on any rational basis. "Whispering Hope" might well be the theme song. Solid information is sparse, but some of the positives and some of the negatives can at least be stated. Among the positives we know the medical marriage is more stable than the usual, at least

in terms of divorce rate. The medical couple have an excellent income and find themselves with an already acquired social status with pleasant associations wherever they settle. About a fourth of their children follow parental modelling and themselves become physicians. The doctor has the potential capacity, at least, for commanding working situations and working hours.

Among the notable negatives are these lugubrious characteristics. The medical marriage, while stable, generally fails by a wide margin to meet its possibilities as a source of pleasure, satisfaction, and gratification. Physicians are considered to be one of the largest single identifiable groups of alcoholics. Similarly, opportunity and life-style determine they can be counted among the heaviest drug abusers. Admissions of physicians to psychiatric services occur about ten times as frequently as their proportion in the general population would suggest. Finally, an inordinate number find a final solution to their internal and external burdens in suicide. Perhaps representative of all these forces at work on the hapless "chosen ones" is the more frequent occurrence, earlier, of heart attacks.

It is evident there are some hazards to mar the endless bliss of medical union. More than 25 years of inten-

The Author

JOSEPH B. TRAINER, M.D.

Dr. Trainer is Clinical Professor of Preventive Medicine and Public Health, past Professor of Medicine and Associate Professor of Physiology at the University of Oregon Health Sciences Center, Portland. He is also Fellow, American Association Marriage and Family Therapists. Dr. Trainer is the Theme Keynote Speaker at the 107th Annual Meeting of the FMA.

sive premarital counseling of medical and other professional students, and the subsequent care of many of those marriages convinces me that much of the dissatisfaction is unnecessary, and that most of the problems indigenous to professional marriages can be ameliorated or avoided by realistic consultations. With this in mind, I want to point up a few of the major predictable dissatisfactions. Having seen them, most intelligent couples can find ways to eliminate some problems, cope with others, and have a far more satisfactory life together.

The information in this paper was gathered fundamentally from the cumulative experience of the individual premarital and marital counseling in our professional student population. Physicians, scientists, nurses, dentists, and executive people seem to share to an unusual degree the same hazards. Much specific information comes from anonymous topics or questions or statements made by spouses at large medical meetings. It has been my practice for a long time in participating in meetings to have separate programs for the spouses. The exchanges in these often become extraordinarily free and in fact, the most frequent challenge is "Why don't you give a session like this to the husbands? They don't seem to know what the problems are at all." I look upon the substance in the same clinical light as an informed clinical insight, rather than as a statistically established block of data of uncertain application to the problems at hand. In that spirit I welcome comments or additions from any reader who feels impelled to do so. I have reasonable information on male physicians and female spouses; fair information on both small children and teen-agers; sparse information to date on women physicians and male spouses and up to now, the least information on lives of single physicians, whether never-married, widowed, or divorced. There is much to be learned.

The Usual Problems of the Married Population

Several years ago Dr. Emily Mudd of the Marriage Council of Philadelphia published an exceptionally acute paper in which she summarized, in the order of frequency, the problems that married couples could identify as having been of some consequence to them. It was interesting that the problems were the same whether the pairs were successfully married or not. The problems occurred in the same order, with only the percentages of occurrence differing between those satisfactorily married and those unsuccessfully married. They are worth reviewing and will seem familiar.

1. *Personality* mismatches and incompatibilities.
2. *Money*: two aspects — we all carry unquestioned, assumptive attitudes about money (savers or spend-

ers) and consider someone with a differing attitude a congenital idiot; we all regard money as the common medium of needs-meeting and rarely have simultaneous consonant needs.

3. *Relatives*: almost all of us have pain-in-the-neck relatives who interfere in some way with family operation.
4. *Sex*: we nearly all enter an essentially sexual relation with an abysmal lack of information about the entire subject, when or how to carry it on, and what part it may play in our own emotional lives.
5. *Pregnancy*: bitter disagreements arise over failure to early discuss and agree on when to start a pregnancy, how often to have one, or to understand the adjustments to be made by both parties during the course of such.
6. *Child Rearing*: each of us is inclined to think the way we were raised must be just about right, considering what successes we are. Differences may be small in this area, but they persist for 10 to 20 years and become lurking volcanoes of emotion and blame.
7. *Household Management*: this is a delusive term which includes all the current turmoil over working wives, gender roles, taxes, bookkeeping, and ordinary household chores.
8. *Recreation*: Inability to agree on what constitutes a good time is an inevitable result of the customary gender raising we have done and continue to do.
9. *Religion*: this rates well below any of the above, and is a cause of discord only when one member of the couple is a dedicated member of an authoritarian church, or both are strong members of greatly divergent groups.

These, then, constitute the readily recognizable difficulties all of us face in attempting to live together in a common existence. They are enough to produce the situation in which more than half of marriages, entered into with such high hopes, end in desertion or divorce.

The Special Hazards of the Medical Marriage

Unlike hats, halos were apparently ordained to have a universal size, i.e., that which fits the head of a doctor. It seems likely that it must have been a concealed lining in the graduation mortarboard which, when the latter was removed, remained attached as a permanent cranial fixture. A major frustration of the wife or family of the doctor is the continually unsuccessful attempt to get the device off to allow him or her to be at one with other mortals. It is difficult to combat essential goodness — and so long as the halo persists in remaining in its neon-lit place, the bearer can hardly be dealt with in ordinary human terms.

The Medical Personality

Birds of a feather do flock together, and the reason one can say the following about the peculiarities of the doctor is that the spouse shares these very same advantages and drawbacks to a remarkable degree. The doctor can be capsulized as a very bright, energetic, well-organized personality, who is single-minded and goal-oriented and who has been taught that detachment is a cardinal virtue. By the large, these qualities do indeed make good physicians but relatively insufferable husbands and fathers — and I suspect mothers.

The Medical Week

Let me quote two characteristic complaints expressed by wives: (1) "Finding time to be together away from our other responsibilities" (2) "Hard to get enough 'quality' time with my doctor husband. His daily schedule drains him." From the outset, lack of time is the major dissatisfaction of the medical spouse. A characteristic breakdown of the 168 hour week will go far to explain this.

Sleep 49 hours; work 60 hours; study groups and medical meetings 6 hours; civic, non-medical activities 2 hours; meal times (some at home) 14 hours; emergencies 10 hours; hobbies or exercise 7 hours. This leaves 20 hours in the week to go to the toilet, get the car serviced, do some essential shopping, handle business matters. If the doctor is unusually effective, he may find six hours a week for the company of his wife, and if he has two children, each will come in for three hours apiece. For someone living in the upper-echelon of society, able to come, go, buy far better than most of his fellow citizens, this does not read like a luxurious life, nor does it carry much weight as family life. Living alone with someone is one of the single best descriptions of the medical marriage.

Communication Lack

"He has listened to people all day and does not want to discuss family matters. If I can take care of it he doesn't even want to hear about it." Again, a characteristic remark from a spouse, and one with multiple reasons. Gender differences, in which the woman expects to solve problems verbally are compounded by the medical training of the male who does not expect to solve problems verbally. He is taught to be uncommunicative. Silence descends, unless the problem for communication is one which is readily expressed in argumentative or pejorative terms. Voices raise, tempers flare and communication is stifled from the outset because of the limited time together of the medical couple. As a con-

sequence communication is limited to what I call "crisis conversation". You spend the little time you have dealing with the nuisance value of the garbage of existence and lose entirely the older habit of talking about life and love and feelings and hopes. Conversation descends to the level of tonsillitis in your kid or whose fault it was the fender got bashed in. Eventually you each come to associate the partner with the problem and communication is no longer joyous or satisfying. Better stick to the weather.

Fatigue

In a fatigued population, the medical group stands out. The doctor who works 60 hours a week is overworked and lives with a chronic fatigue state. This affects his disposition in exactly the same way it affects his four-year-old. His disposition and resilience plummet. He is no joy to be around. Correspondingly, if he is doing that, his spouse is taking 80 percent of the responsibility and work for operating the house, probably the accessory business ventures undertaken in the name of tax exemptions, and being nearly totally responsible for the upbringing of the children. This is the equivalent of the single-parent household, with all its problems, and the probability is overwhelming that the spouse is seething with repressed rage and frustration at the overload. Both partners are chronically fatigued, and fatigue speaking to fatigue is rarely relaxing, fun, joyous, or uplifting. Fatigue insidiously makes life incredibly dull and each partner is quite certain where the unspeakable dullness comes from.

Authoritarianism

The disciplines of medical training can turn the most humble of personalities into the most authoritarian. Practice compounds the sin beyond all recognition. When you spend 60 hours a week dictating to a succession of patients what and when they shall eat, how much they shall sleep, what medicines they shall take and when, what exercise they may have or not have you become accustomed to the medical heritage of "giving orders". These are not suggestions. It is the easiest of mental tricks to transform this laudable professional trait into a general personality trait, become convinced of your omniscience and carry it all home. The inevitable result will be the development of a cordial dislike between your spurious self and those who have to live with you. One child wrote "I'm sick of being bossed around" while another, wise beyond her years, complained "My Pop worries too much about my sex life, which I don't have because I'm too young." Doubts are seldom clouds across the authoritarian mind.

Problems of the Doctor's Child

Having forgotten most if not all the genetics learned during medical education, the physician is inclined to endow all his or her offspring with much the same intelligence, drive, perception, and perfectionism as he or she conceives is parentally embodied. This puts the child on the wrong career track, may well put him to seeking performance goals of which he is not capable, and may succeed in suppressing whatever natural talents he possesses. The community reflects this, teachers often berate children for not doing better when they are the children of a physician. Peers may pose a similar problem and are reluctant to visit the doctor's house from uncertainty or even fear of how to deal with this all-powerful figure.

One doctor asks "How do you properly advise, manage, and live with your children in college?" It apparently never occurred to him that there is a cycle to life and family, and at least ten years had passed since that query was pertinent. Another victim of the above thinking asks "How to encourage my children to be highly motivated to do their very best work during their school years." The questioner no doubt has no idea that "All work and no play make Jack a dull boy" might be an apt self-description.

Protracted Adolescence

Professional education, extending on to ages 25 and 30, produces an interesting side product, which may be visible best to the doctor who has to take care of such a population. These otherwise advanced, intelligent and capable young professionals remain adolescents in many respects. This seems to me to be a natural result of prolonged dependency financially, and a painfully extended dependency professionally — for some, extending to well-recognized "Hospitalitis". Adolescence at any age is a poor state in which to get a marriage and family underway. One wife said, "There is too much criticism of each other" and criticism never cemented a pair bond in the

history of humanity. Another complained outright that her main problem was "Waiting out each other's growing pains." Being aware of these pitfalls is probably the best prophylaxis.

Lack of Self-Realization of the Spouse

I commented earlier on the great similarities of personality in medical husbands and wives. This emerges with emphasis from the mid-life wife. "I want to be recognized not only as a wife and mother, but as a person." Or, "How can I maintain my own identity while still caring for my husband and children." And another, "I'm tired filling lonely hours with 'busy work' now that the children are growing up and leaving." With another variation, frequently heard, "How can I adapt my changing role as my children get older. My husband doesn't want a working wife." The ancient gender hangovers have not yet left us.

It may be that the best line of thought the physician husband can entertain for a while is "What is so fascinating about living with and taking care of a removed, pre-occupied partner who puts his wife in second place most of the time?"

We have very good lives. Can't we look at these things and make them better? We could have the best, if we but would.

Bibliography

Trainer, Joseph B., M.D., So . . . You Worried A Doctor, Portland, Oregon, Imprint, UOMS, 1970.

Trainer, Joseph B., M.D., *The Physician as a Marriage Counselor*, National Council on Family Relations, Family Coordinator, 1973.

Trainer, Joseph B., M.D., *Sexual Incompatibilities*, Journal of Marriage and Family Counseling, April 1975.

Trainer, Joseph B., M.D., *Physiologic Foundations for Marriage Counseling. Human Mating and Marriage*, St. Louis: C.V. Mosby Co., 1965.

- Dr. Trainer, University of Oregon, Health Sciences Center, Portland, Oregon 97201.

The Relaxation Response: Your Inborn Capacity to Counteract The Harmful Effects of Stress

Herbert Benson, M.D. and Irene L. Goodale

Our modern society has undergone rapid technological progress, and has forced most individuals into a world of change. There has been a need to adjust behaviorally to both the beneficial and the deleterious effects of this fast-paced, pressured life. These behavioral adjustments are emotionally and physiologically stressful, and are believed to have undesirable effects on health. Few individuals know how to alleviate these harmful sequelae. In fact, many have come to accept excessive stress as a necessary element of their lives. Yet, there is an innate capacity, the relaxation response, which counteracts the deleterious physiologic effects of our changing world.

Stress and the Fight-or-Flight Response

Stressful situations, those requiring behavioral adjustment, activate the emergency reaction or "fight-or-flight response" which was first described by Walter B. Cannon.¹ He reasoned that this innate, integrated response prepared an animal for such behavioral features as running or fighting when faced with threatening environmental situations. The emergency reaction, also termed the defense-alarm reaction, is an integrated physiologic response that gives rise to a coordinated activation of the sympathetic nervous system. It is associated with increases in blood pressure, heart rate, and respiratory rate, and markedly increased blood flow to skeletal muscle.^{2 3}

The fight-or-flight response is still a necessary and useful physiologic feature for survival. However, the

stresses of today's society have led to its excessive elicitation while at the same time, its behavioral features, such as running or fighting, have become socially inappropriate or unacceptable. Those who experience greater environmental stress and, therefore, more frequent elicitation of the fight-or-flight response are believed to be at greater risk to develop prevalent and serious diseases such as hypertension.⁴ Hypertension, obviously of far greater significance than as simple an index of stress, is perhaps the most important factor in the development of myocardial infarctions and strokes, diseases which account for more than 50% of the deaths each year in the United States. Therefore, it is not surprising that various degrees of hypertension are present in 15% to 33% of the adult population of the United States, affecting between 23 million and 51 million individuals.

If hypertension could be prevented, the excessive cardiovascular diseases might be reduced. Consequently, the control of the effects of stressful situations are of considerable concern. In addition to hypertension, stress has been implicated either as a causative or an exacerbating factor in disease states in which excessive sympathetic nervous system activity is undesirable: anxiety reactions, angina pectoris, Raynaud's disease, and cardiac arrhythmias.

The Relaxation Response

The relaxation response is the physiologic counterpart of the fight or flight response. The physiologic changes of this response were first described by Dr. Walter R. Hess in the cat.⁵ He electrically stimulated an area of the anterior hypothalamus and induced hypodynamia or adynamia of skeletal musculature, decreased blood pressure, decreased respiratory rate, and constriction of the pupils. Such a response was interpreted by Hess as "a protective mechanism against overstress (which promotes) restorative processes".⁵ In humans, the relaxation response consists of physiologic changes opposite to those of the fight-or-flight response and is characterized by changes consistent with decreased sympathetic nervous system activity.^{6 9} These changes

The Authors

HERBERT BENSON, M.D.

Dr. Benson is Associate Professor of Medicine and Director of the Division of Behavioral Medicine at Harvard Medical School. He is also author of the best-seller, The Relaxation Response (Morrow, 1975).

IRENE L. GOODALE

Ms. Goodale is Research Assistant, Division of Behavioral Medicine, Department of Medicine, Beth Israel Hospital, and the Charles A. Dana Research Institute, and the Thorndike Laboratory, Harvard Medical School, Boston, Mass.

include decreased oxygen consumption, blood pressure, heart rate, respiratory rate, and arterial blood lactate, and a slight increase in resting forearm muscle blood flow.¹⁰ The electroencephalogram demonstrates an increase in the intensity of slow alpha waves and occasional theta wave activity. The physiologic changes occurring during the relaxation response are different from those of sleep or of sitting quietly with closed eyes.

To combat the harmful effects of stress, one need only elicit the relaxation response. Techniques which enable an individual to bring forth the relaxation response and its associated physiologic changes have existed for centuries, usually within a religious context.^{6,7} Practices eliciting the relaxation response may be found in practically every culture of man: in Christian and Jewish meditative prayers; in Eastern religions such as Zen, Hinduism, Shintoism, and Taoism; and in Eastern practices such as Transcendental Meditation and Yoga. Despite the diversity of these techniques, four elements appear to be integral and are necessary to elicit the response in its classic fashion: a quiet environment; decreased muscle tension; a mental device, i.e., a sound, word, or phrase repeated silently or audibly; and a passive attitude.

These four common elements are found in "The Prayer of the Heart" or "The Prayer of Jesus," a repetitive prayer used in meditation and mystical practices since the beginning of Christianity.¹¹ The prayer was described in the fourteenth century at Mount Athos in Greece by Gregory of Sinai:

Sit down alone and in silence. Lower your head, shut your eyes, breathe out gently, and imagine yourself looking into your own heart. Carry your mind, i.e., your thoughts, from your head to your heart. As you breathe out, say 'Lord Jesus Christ, have mercy on me.' Say it moving your lips gently, or simply say it in your mind. Try to put all other thoughts aside. Be calm, be patient and repeat the process very frequently.

In Judaic literature one finds descriptions of similar meditative exercises. In an early form of Jewish mysticism called Merkabolism, which dates back to the second century B.C., an individual sat with his head between his knees and whispered hymns, songs, and repeated the name of a magic seal.¹²

In the East, meditation which brought forth the relaxation response developed much earlier and became a major element not only in religion but also in everyday life. Age-old practices of Yoga strive for "union" of the self with a supreme being or principle. The meditation of Yoga involves concentration upon a single focus to exclude all thoughts that are associated with everyday

life.^{6,13}

Secular techniques, such as autogenic training, may also produce the physiologic effects characteristic of the relaxation response.¹⁹ The relaxation response is not unique to any specific technique or religious practice. In fact, investigations have demonstrated that the physiologic responses associated with the relaxation response can be elicited equally well by many techniques.⁶

A noncultic technique to elicit the relaxation response has been used in our laboratory and may be easily learned by following a simple set of instructions.^{7,14} This technique is but one of the scores of techniques which incorporate the four basic elements which elicit the relaxation response. The instructions are:

1. Sit quietly in a comfortable position.
2. Close your eyes.
3. Deeply relax all your muscles, beginning at your feet and progressing up to your face. Keep them deeply relaxed.
4. Breathe through your nose. Become aware of your breathing. As you breathe out, say the word "one" silently to yourself. For example, breathe in . . . out, "one;" in . . . out, "one;" etc.
5. Continue for 20 minutes. You may open your eyes to check the time, but do not use an alarm. When you finish, sit quietly for several minutes at first with closed eyes and later with opened eyes.
6. Do not worry about whether you are successful in achieving a deep level of relaxation. Maintain a passive attitude and permit relaxation to occur at its own pace. When distracting thoughts occur, ignore them and continue repeating "one." With practice, the response should come with little effort. Practice the technique once or twice daily, and not within two hours after any meal, since the digestive processes seem to interfere with the elicitation of anticipated changes.

The regular elicitation of this response has been shown to be an effective therapy of these diseases in which excessive sympathetic nervous system activity is undesirable: hypertension,¹⁵ premature ventricular contractions,¹⁶ tension and migraine headache,¹⁷ and anxiety.¹⁸ The relaxation response should be viewed as another effective approach to be added to existing therapies. For example, it may replace drug therapy in labile and mild hypertension. In moderate and severe hypertension, its use should bring about better blood pressure control with fewer drugs.

The relaxation response is an innate, natural physiologic response. Its side effects are equivalent to those of praying twice a day and is therefore safe. Compare these properties to those of the side effects of commonly used

drugs. The elicitation of the relaxation response will be accepted by patients who are concerned about the possible adverse properties of other medical treatments. Finally, compliance with a regimen that includes the elicitation of the relaxation response will be enhanced by choosing a word, sound, prayer or phrase for repetition that conforms to the belief system of the patient. We have had considerable success with repetitive simple prayers such as "The Prayer of the Heart" or a phrase from the twenty third psalm.

Our work should not be interpreted as a mechanistic or scientific explanation of prayer. It is not. Rather it is a reaffirmation of what religious people have been telling us for centuries: namely, that prayer is good for you. These people are probably right.

Conclusion

Psychological, emotional, and behavioral events result in physiologic changes. By appropriate use of behavioral intervention, desirable physiologic alterations may be made. For example, use of certain simple behavioral techniques lead to elicitation of the relaxation response and its corresponding decreased sympathetic nervous system activity. Such nonpharmacologic interventions are often effective treatments for organic diseases, and may decrease the need for drug therapy.

Acknowledgement

Supported in parts by Grants HL-22727 and HL-07374 from the National Institutes of Health.

References

1. Cannon, W. B.: The Emergency Function of the Adrenal Medulla in Pain and the Major Emotions. *Amer. J. Physiol.*, 33:356, 1914.
2. Abrahams, V. C.; Hilton, S. M.; and Zbrozyna, A. W.: Active Muscle Vasodilatation Produced by Stimulation of the Brain Stem: Its Significance in the Defense Reaction. *J. Physiol.*, 154:491, 1960.
3. Abrahams, V. C.; Hilton, S. M., and Zbrozyna, A. W.: The Role of Active Muscle Vasodilatation in the Altering Stage of the Defense Reaction. *J. Physiol.* 171:189, 1964.
4. Gutmann, M. C., and Benson, H.: Interaction of Environmental Factors and Systemic Arterial Blood Pressure: A Review. *Medicine*, 50:543, 1971.
5. Hess, W. R.: The Functional Organization of the Diencephalon. New York, Grune and Stratton, 1957.
6. Benson, H.; Beary, J. F., and Carol, M. P.: The Relaxation Response. *Psychiatry*, 37:37, 1974.
7. Benson, H.: The Relaxation Response. N.Y., William Morrow and Co., 1975.
8. Wallace, R. K., and Benson, H.: The Physiology of Meditation. *Sci. Amer.* 226:84, 1972.
9. Wallace, R. K.; Benson, H., and Wilson, A. F.: A Wakeful Hypometabolic Physiologic State. *Amer. J. Physiol.* 221:795, 1971.
10. Levander, V. L.; Benson, H.; Wheeler, R. C., et al.: Increased Forearm Blood Flow During a Wakeful Hypometabolic State. *Fed. Proc.*, 31:405, 1972.
11. French, R. M. (trans.): The Way of a Pilgrim. New York, Seabury Press, 1968.
12. Scholem, G. G.: Jewish Mysticism. New York, Schocken Books, 1967.
13. Eliade, M.: Yoga: Immortality and Freedom. Translated by W. R. Trask. London, Routledge and Kegan Paul, 1958.
14. Beary, J. F., and Benson, H.: A Simple Psychophysiological Technique Which Elicits the Hypometabolic Changes of the Relaxation Response. *Psychosom. Med.*, 36:115, 1974.
15. Benson, H.: Systemic Hypertension and the Relaxation Response. *New Engl. J. Med.* 296:1152-1156, 1977.
16. Benson, H.; Alexander, S., and Feldman, C. L.: Decreased Premature Ventricular Contractions Through the Use of the Relaxation Response in Patients With Stable Ischemic Heart Disease. *Lancet* II:380-382, 1975.
17. Benson, H.; Klemchuk, H. P., and Graham, J. R.: The Usefulness of the Relaxation Response in the Therapy of Headache. *Headache* 14:49-52, 1974.
18. Benson, H.; Frankel, F. H.; Apfel, R.; Daniels, M. D.; Schniewind, H. E.; Nemiah, J. C.; Sifneos, P. E.; Craswell, K. D.; Greenwood, M. M.; Kotch, J. B.; Arns, P. A., and Rosner, B.: Treatment of Anxiety: A Comparison of the Usefulness of Self-Hypnosis and a Meditative Relaxation Technique. *Psychother. Psychosom.* 30:299-242, 1978.
19. Luthe, W. (ed.): Autogenic Therapy. Vols. 1-5. New York, Grune and Stratton, 1969.

- Dr. Benson, 330 Brookline Avenue, Boston, Mass. 02215.

The Prevention of Physician Impairment

John-Henry Pfifferling, Ph.D.,
Jeffrey C. Blum, M.D., and William Wood, M.D.

Introduction

The prevention of physician impairment requires concerted efforts from every sector of the medical profession and the general public. Physicians, medical students, and family members must be instructed on the conflicts inherent in the practice of medicine within the United States medical care system.

The often unrealistic expectations brought to the role of the physician by patients, practitioners, medical educators, and other health workers must be openly confronted so as to reduce the overburden so commonly felt by physicians and trainees. Conflicts and inconsistencies abound in each era of physician development: premedical, medical and continuing education.

At the premedical level, students are often poorly prepared for the variety of professional work options available in the health arena. They are not adequately informed of the risks associated with the physician role and status, and are often limited in exposure to clinical experiences.

At the formal education level medical students are confronted with a shortage of time for learning a vast number of facts, insufficient role model types and feedback, unclear objectives for professional responsibility, incongruent evaluation and curricular activities, and major conflicts between time for self and time for the profession. The medical student has little time and guidance to develop a sense of him/herself as a professional person with an ability to accept areas of failure, and with rewarding personal life that extends beyond the practice arena.

Following the completion of formal education, the physician must deal with the conflicts of practice and/or academic roles that serve as sources of professional

strain. Physicians may have (1) inadequate resources within which to perform their work, (2) limited objective feedback on their professional performance, (3) inadequate client gratitude and feedback, (4) segmented and incomplete relationships with their patients, (5) perceived work environment infringement on their professional decision-making and autonomy, (6) numerous routine tasks, (7) a lack of collegiality, and (8) a personal confrontation with failed expectations. These multiple factors play single or additive roles in developing emotional and physical stresses upon the physician producing limited or marked impairment upon professional and personal life. Awareness of these sources of strain and anticipatory guidance to deal with their emotional toll helps to prevent physician impairment.

The Problem of Physician Impairment: Definition, Natural History, and Prevention

Physician impairment is a generic concept in which personal problems interfere with the reasonable performance of medical activities including a continued ability to maintain currency in medical content and a personal capacity to contribute to health promotion through interpersonal skills. Impaired physicians are highly susceptible to the development of overt symptoms such as chemical or alcohol dependency. This usually develops in a progressive manner. In a recent review, Talbott and Benson found that 12 to 14 percent of physicians have had, currently have, or, in their opinion, will have problems with alcohol or drugs.¹ The incidence and prevalence of other impairing conditions, such as psychiatric or emotional problems is thought to be high, but the epidemiologic data is inadequate to define the extent of the problem.²

Clues to physician impairment are found in both the preclinical and the clinical settings (symptoms may be marked and severe or may be subclinical). Medical students may be regularly using mind-altering substances or indulge in episodes of excess use to gain added energy, relax, or for relief of stress. Residents may indulge in consistent use of mind-altering substances, repeatedly make errors in cases requiring routine clinical judgments, avoid experiences that are relevant to their stated practice specialty, and make apparently illogical changes of train-

The Authors

JOHN-HENRY PFIFFERLING, PH.D., JEFFREY C. BLUM, M.D.

Dr. Pfifferling and Dr. Blum are Co-Directors, Center for the Well-Being of Health Professionals, Inc., Chapel Hill, N.C.

WILLIAM WOOD, M.D.

Dr. Wood is Director of the Office of Continuing Medical Education, School of Medicine, University of North Carolina.

ing paths. Both young and more mature physicians may self-prescribe and use drugs, alienate themselves from family, community and colleagues, display marked changes in office, hospital practices or duties, and demonstrate deteriorating physical or personal care. Talbott and Benson review in detail these characteristics of behavior.¹

It appears that the probable history of impairment includes a vulnerable individual selected by the usual medical school admission process, an educational environment that precludes allowing the student to deal with the emotional toll associated with achieving medical professional status and responsibility, a societal role strain that demands unrealistic behavior, and a professional society that disallows open discussion of physician role stresses — particularly the needs of the physician as a person. As the American way of life decreases support from continuity of community, family, and work, greater stresses are added.

Preventive efforts must be extended back through residency, medical school, and even pre-medical training, and supported by leaders in the relevant professional environments. In addition, other important adjunctive areas of intervention include the family of the physician, co-workers, and patients. Family members play a vital role in prevention, early recognition, and confrontation. Co-workers must learn to recognize early clues to impairment and have (knowledge of) supportive strategies to prevent lowered physician morale. Patients must be educated to the mass of competing influences in the modern medical setting that may interfere with a quality doctor-patient relationship. New contracting relationships providing realistic expectations between doctor and patient can help establish more efficient allocation of health responsibilities.

Premedical Education

The Problem. Our current premedical education and advising system (1) prepares its students poorly for the varieties of options available as a medical care provider, (2) inadequately prepares premedical students for the risks and conflicts associated with being a doctor, and (3) gives limited or no exposure to a broad variety of clinical, field experiences. Premedical training can prepare students for the realities of medical training and practice, help students to better self-select medical or non-medical careers and begin anticipatory training for the emotional and intellectual toll inherent in being a doctor.

Suggested Interventions. Premedical programs should allow the student academic credit for field experiences in a variety of medical settings. Students in these programs should be exposed to the failures, frustrations,

uncertainty and successes associated with medical practice. Debriefing experiences after field projects are important opportunities for self-reflection and career planning. Ideally these debriefings can be conducted by both practitioners and advisors skilled in career counseling.

Opportunities that allow the premedical student to understand the enormous amount of routine in medicine can be helpful in preparing them for the reality of the physician role. An encounter with a recovered, impaired physician can be useful in preparing them for some of the risks associated with trying to practice perfectionistic medicine. They can also be prepared for their own feelings when in the patient role.

Premedical advisors need to be better prepared as career counselors for future medical and health care practitioners. They need thorough exposure to the conflicts and frustrations that lead to the problems of burn-out and impairment. They and their students can read biographical sketches about the difficulties in being a doctor, and plan exercises that reinforce coping behavior for stress situations.

Premedical students can be better prepared for understanding the roles, attitudes, and views of health care workers in order to better communicate as physicians with nurses, hospital administrators, patient advocates, etc. Insight into the meaning of the illness situation to the patient and to the provider can also be gained from systematic exposure to materials and exercises on the patient role. Courses on the anthropology of medicine, medical sociology, medicolegal values and ethics can offer students insight into the complexity of the modern medical world in advance of their immersion into medical training.

The practicing health professional and trainee can be a powerful resource in realistically preparing the pre-medical student for a potential career in the medical arena. Simultaneously, young pre-professionals can non-threateningly enter the practice setting and consciously seek the asset areas of the professional role — reflecting these benefits to the busy professional, thereby countering the problem-oriented view of the practitioner.

Medical Education

The Problem: Limited time is available for the medical student to reflect on individual professionalization — a process with important benefits and risks. Rigorous schedules demanding highly factual education often leads to a transformation from altruistic, conscientious attitudes to cynicism and myopic attitudes that threaten professional pride. The medical student has little time and guidance to develop a sense of him/herself as a professional person with a working attitude towards failure

and with a rewarding personal life that extends beyond the practice arena. Medical students are forced into a ritual of self-sacrifice, perseverance, competitiveness, and denial of universal psychological needs. The physician's work role, commonly including ritual dependence and deference is internalized as the growing personality of the medical student.

Suggested Interventions: Medical school and house-staff programs that attempt to reduce the stresses of medical training have found the following actual or suggested interventions.

Medical students need workshops on coping with medical school stressors such as loneliness and isolation, examination anxiety, fear of incompetency, changing self-concept, dependency feelings, problems with relationships, workload, dealing with sexuality, lack of role models, and social, sleep and sexual deprivation. Many coping and stress reduction skills are now well-known by counseling professionals, but not systematically taught and verified as skills for medical trainees.

Experiential workshops on centering skills with opportunities to develop self-respect and self-affirmation are crucial for the medical trainee in an environment that stresses individualistic problem-solving.

Medical trainees need experiential exposure and reinforcement in acquiring social support, stress reduction skills, life planning tools, confrontation techniques, negotiation strategies, and peer counseling skills. Each of these areas of conflict management are useful both for trainee survival and as patient education strategies. Physicians must function in many non-medical model capacities and these interpersonal skills, if reinforced by role models, can contribute to preparing efficient, conscientious clinicians. Medical educators must incorporate opportunities for their trainees to gain coping skills into the curriculum, as so many of the modern clinician's demands are in human relations problems that are not amenable to purely medical solutions.

Access to child-care services, financial management advisors, time management skills, and participation in a personal health care plan reduce aggravating stressors in the trainee role that deplete the student's available learning energy. Subsequent use of these skills reduces the impact of common practice problems such as budgeting time and coping with practice management demands.

Medical students and housestaff need exposure to "recovery" models, such as recovered alcoholics, to balance the domination of exposure to failure (non-cure) in the tertiary care population. Exposure to "recovered" populations also transmits revitalizing energy needed in coping with the inevitable failures associated with tertiary care patients.

Medical students must be exposed to their colleagues as patients so that they can be better prepared

to be a patient themselves and to care for their physician patients. Exposure to recovered "impaired" physicians as teachers can prepare the student for coping with his/her own worst fear — being helpless or becoming impaired. Recovered physicians demonstrate for the medical student the creative use of illness and enhance the acquisition of hope models. A rotation with a physician advocacy group, such as a state medical society committee on disabled physicians, can prevent impairment by modeling fraternal caring and reducing the negative energy associated with the town-gown problem.

Table 1 lists many coping strategies valuable in prevention and further discussed in *Beyond Survival*.³ In addition, housestaff programs would benefit from two special coping activities: (1) the availability of unstigmatized, part-time residency programs, and (2) ready access to counselors with life planning and career planning skills for physicians. A list of preventive strategies for housestaff is offered in Table 2.

At present, the overwhelming evidence from studies of housestaff indicate that they are too fatigued from work to maintain their caring skills for both their patients and themselves. The many loyalties and obligations of the housestaff role, and service setting, offer many frustrations for the resident, and guidance is badly needed so

Table 1. — Preventive Options for Medical Students
Workshops on Coping with Medical School Stress:
Centering exercises
Social support
Stress reduction
Life planning
Student/Faculty/Administration problem-solving groups
Confrontation skills
Interpersonal skills
Negotiation and conflict resolution
Practice management
Participation in retreats
Access to support groups run by other health workers
Proximal child care services
Flexible graduation plan
Prepaid personal health care plan
Recovery and rehabilitation rotations
Clerkship with Impaired Physician's Committee
Counseling
Group therapy
Recovered physician lectures
Courses in marital health

Table 2. — Activities That Reduce Medical Student Housestaff Stress

Participation in support groups
Option of part-time residency medical school years
Career planning counseling
Psychological counseling
Proximal child-care services
Financial and time management advisors
Organizational conflict seminars
Personal and professional medical development seminars
Interpersonal communications skill sessions
Negotiation skills
Paid sick-leave policies
Inter-generational social activities
(Ex. medical society/training programs)
Family orientation programs

that career planning is carefully addressed rather than as a spinoff to the treadmill existence of the resident role. Career planning counselors could also function as true resident advocates, allowing the residents some needed freedom for career decision-making.

Housestaff also confront conflicts between personal identity and career identity, competition between time for self and family, and a personal definition of professional responsibility. As members of a recently initiated family they also feel the pull of spouse and parenting pressures. Too often the training model is too rigid to allow a reduced work schedule as an acceptable option. The availability of the option of a flexible residency program is an important component in a preventive program.

Continuing Medical Education

The Problem: Physicians, as all other professionals, suffer from a crisis of morale symptomatically demonstrated as burnout. Awareness of the source of burnout and anticipatory guidance to deal with their emotional toll helps to reduce or prevent physician impairment. Some of the sources for these crises are (1) a loss of the expected energy derived from a therapeutic doctor-patient relationship because of the encumbrances associated with administrative, legalistic, technical and societal obligations;⁴ (2) inadequate resources in which to perform work; (3) inadequate client gratitude and feedback; (4) incomplete relationships with patients; (5) perceived bureaucratic infringement on physician autonomy; (6) job routine; (7) lack of collegiality; and (8) confrontation with failed expectations.

Suggested Interventions: Awareness of the conflicts

and morale reducing activities of the medical role suggests that physicians must be aware of their changing career goals and modified aspirations. Their goals and their practices go through a developmental cycle. Five-year CME plans and assessments should be incorporated into the preventive care plan of a conscientious practitioner. Feedback from the practice or academic setting should be routinely available, and, where educational or interpersonal skills are deficient, a plan developed for correction. If the practitioner is depressingly frustrated by the routine of the practice, an aspect of the CME plan can be oriented towards redirection or retraining. In the academic setting, the physician may be unstimulated by a primarily research or teaching bent and wish to redirect his/her energies into some alternative activity. Imaginative practice/academic combinations need to be developed that reflect where the physician's interests are at that moment. Most current medical roles are far too rigid to satisfy the diversity of personal and professional styles that physicians bring to their work role. The creative strengths of the physician are rarely openly discussed in employment interviews or designed into the contract of the academician. If physicians fail to affirm their strengths as they negotiate a position, burn-out potential is increased. At the very least, one should go into the practice environment expecting to regularly evaluate professional and personal values, and ideally, spend some time designing an input system for continuing professional education and career goal planning.

Organized medicine must address practice stressors so the individual physician does not continue to feel as if he or she is the only one with a problem. A useful start has been made with the American Academy of Family Physician's regionalized workshops on *Coping with Practice Stressors*. We have led many groups of physicians in problem-solving exercises designed to identify recurrent practice/work stressors, cope with them by peer counseling, and experience the benefits of a supportive environment. We have also found that "anthropological" visits devoted to (1) shadowing the physician for a day, and (2) analyzing the practice stressors in a day devoted to caring for the physician are a useful intervention. When physicians leave their practice setting and spend a day with another physician in a distant community — devoted to dealing with practice stressors — both parties benefit from a novel experience.

Physicians can also take steps to enhance their own well-being by life style changes and by clarifying their own professional goals and values. For example, many recurrent stressors in a practice result from unclear communications about expected services, roles, or responsibilities. The formulation of a set of Principles of Practice sets down what is expected that the practice will accomplish and how to accomplish the goals. Without a Principles

of Practice document, one virtually guarantees miscommunication between partners, other health workers, and patients. The Principles of Practice document assists in recruiting new physicians to a group or helps one as a candidate decide whether one wishes to join an "unorganized" group. A Principles of Practice statement should contain the practice group's approach to patient care, quality control, patient education, privileged communications, continuing medical education, fees, etc. Without documentation of these objectives, the practice controls the physician rather than the obverse. Where philosophy and practice approach is clear, and goals are specific, one can audit actual performance and design appropriate interventions.

A clear Principles of Practice document reduces conflict over delegation of responsibilities, overburden caused by patient demands, and a host of recurrent practice stressors. The more carefully and clearly defined are the Principles of Practice, the greater the congruence between the expectations of oneself and one's partners, other health workers, and patients. Recruitment of physicians with similar values is ensured and retention of both providers and patients with shared goals is fostered. A high quality communication system is also structured into the practice world. Partnership divorce may also be prevented or reduced in emotional toll in practices with Principles clearly formulated.

We also recommend participation in a support network that allows regular opportunities to self-disclose practice-related stressors in an unqualified, supportive environment. Too few physicians have the needed support available from participation in a support group whose primary aim is to give nonjudgmental support. Participation in a support group protects one from feelings of intense loneliness and letting one's own internal critics reduce self-esteem. Group members can not only replenish one's need for nurturance, but they can offer their coping behaviors as ways of reducing personal stress. They are not therapy groups, are leaderless, composed of peers, and do not require a professional therapist. They do require genuineness, empathy, and peer concern. For physicians, participation requires some risk taking in disclosing personal needs, an area that is poorly rewarded in the professional medical culture. One must also guard against letting the group become an outlet for hostility and contagious morbidity. This can be done by remembering that the group is primarily oriented to sharing of support and positive regard.

Physicians can also benefit from attending much more carefully to their own personal life style and their management of stress and skills at relaxation. Courses in stress management, time allocation, conflict management, and life planning are needed for modern physicians. The multiple roles required in the physician role,

and a rigid training model that does not address the issues associated with the social, economic, legal, and valuative life of a practice predisposes the conscientious physician to professional burnout.

Physicians must balance the rewards and frustrations of the medical life with success in other sectors of life. In workshops on burnout, we are always on the lookout for individuals that invest their entire self-esteem in their professional role. These individuals often are poorly prepared to deal with the inevitable failed expectations in medical practice. Training skills in disidentification — a particularly useful coping skill in which one attempts to disidentify ego from a momentary feeling — seems to be a useful tool for these individuals.

Conclusion

The prevention of physician impairment with the simultaneous enhancement of well-being is not only necessary, but crucial if we are to reduce professionally and personally crippling disquietude, burnout, and impairment among physicians. Impaired physicians use defensive denial to discount their disability and commonly fail to reach for help when they are troubled. Efforts to reduce the problem of impairment must, therefore, be well-supported and well-funded. Professional and non-professional organizations and individuals must cooperate in raising the consciousness level about the prevalence of impairment, and publicize the resources available for support.

The costs of physician impairment are socially, economically, and professionally staggering. Rehabilitation is costly, lengthy, and extremely difficult, although major gains have been made in the last few years with aggressive intervention programs. But these few successful programs are well-funded, led by committed physicians, and supported by a combined effort including medical societies, auxiliaries, state medical boards, and other professional groups.

The prevention of physician impairment should be a high priority in allocating resources in the medical arena; currently it is rudimentary. Continued support is needed to bolster the work of the Department of Mental Health of the American Medical Association, its associated state medical society committees, the Committee on Mental Health of the American Academy of Family Practice, the Committee on Physician Impairment of the American Psychiatric Association, and independent organizations committed to prevention.

References

1. Talbott, G.; Benson; Douglas and Earl. "Impaired Physicians — The Dilemma of Identification." *Postgraduate Medicine*, 68(6):56-64, 1980.
2. Plifferling, John-Henry. *The Impaired Physician: An Overview*. Health Sciences Consortium.

- ium: Chapel Hill, 1980.
3. Tokarz, J.; Patrick, et al. Beyond Survival. Resident Physicians Section of the American Medical Association, 1979.
 4. Lipp, Martin R. The Bitter Pill. Harper and Rowe: New York, 1980.

Resources

Committee on Mental Health, American Academy of Family Physicians.

Department of Mental Health, American Medical Association. Biannual Proceedings of the Conferences on Impaired Physicians and Newsletter.

Pfifferling, John-Henry. The Impaired Physician: An Overview. A self-instructional monograph, available from the Center for the Well-Being of Health Professionals, Inc. 200 Eastowne Drive, Suite 213, Chapel Hill, NC 27514, or through the department of Provider Relations, Blue Cross Blue Shield Associations.

- Dr. Pfifferling, 200 Eastowne Drive, Suite 213, Chapel Hill, North Carolina 27514.

Occupational Stress and Productivity: Strategies for Physical and Fiscal Health

Arthur H. Rosen, M.D.

Physicians in all specialties are frequently confronted with patients whose symptoms appear to be related to their occupations. A cross-section of patients might include a hypertensive executive, an alcoholic salesman, a secretary with persistent tension headaches, a workaholic entrepreneur and a blue collar worker with chronic low back pain. Though the etiology of the problem can be traced to particular job stressors, the physician does not have the prerogative of therapeutic intervention into the working lives of his patients.

The High Costs of Stress

The frustrations physicians have experienced in coping with work-related illness is matched by concern in the Executive Suite. The industrial balance sheet absorbs the impact of employee stress. It has resulted in accelerating health care and disability costs related to the behavior, habits and lifestyles of employees. Furthermore, employee health, motivation and satisfaction affect corporate productivity. In a labor-intensive industry where salaries and benefits are a dominant expense, the results can be catastrophic.

According to the New York Times National Economic Survey,¹ productivity is a function of capital, technology and people. During 1960-1965 the average yearly increase in productivity in non-farm workers was 3.6%. Between 1976-1980 this annual increase had fallen to a mere 0.2%.

Federal regulations enacted through Occupational Safety and Health Administration, once thought to be a cost-effective approach to maintaining employee health, have recently come under serious review for their failure to significantly affect the health of workers. Instead of reducing corporate costs for health care, disability and lost productivity, the regulatory agencies have adversely

affected the bottom line by entangling industry in a morass of red tape. They have frequently forced compliance with regulations that are neither applicable nor appropriate to the health and safety needs of an individual organization.

The national health bill for 1980 was \$224 billion, or 9.5% of the GNP. Corporations pay a major part of this bill. General Motors spends \$1.4 billion annually, twice its expenditure of only five years ago. The United States Clearinghouse for Mental Health Information recently reported that, "... there has been a \$17 billion annual decrease in U.S. industry's productive capacity over the last few years due to stress-induced dysfunctions."²

This estimate is conservative when one examines the true costs of stress. Major corporate liabilities resulting from stress are known as the five "A's" of Industry: *Alcoholism, Absenteeism, Accidents, Apathy and Antagonism.*

Alcoholism affects 4.5 million employees and results in high medical costs and impaired productivity. Each alcoholic employee loses an average of 22 work days per year. According to the Harvard School of Public Health, alcohol alone accounts for \$14 billion in medical costs and disability payments and another \$14.8 billion in lost productivity. These figures do not include the incalculable loss to a company when a valued 45-year-old executive is forced to retire, relocate or change jobs because of medical disability. He takes with him his experience and 20 years of potential contributions to the Corporation. The hard data also do not reveal the adverse effect he has had on work groups, subordinates and clients or customers.

The National Institute of Occupational Safety and Health (NIOSH) estimates that 60-85% of all industrial accidents are stress-related, due to emotional distractions, skill fatigue or mental lapses. Employees in high stress jobs also have a higher incidence of accidents off the job. The Presidential Commission investigating the Three Mile Island incident reported that management overlooked the fact that any system depends on the managers, technicians and operators who run it, their competence, training, the decisions they make, and the conditions under which they must make them. Stress,

The Author

ARTHUR H. ROSEN, M.D.

Dr. Rosen was formerly Associate Medical Director at a Multinational Company; is a practicing physician in Behavioral Med., Jacksonville, Florida. He is Director of Industrial Rehabilitation at the Cathedral Rehabilitation Center and a consultant to industry on stress and medical risk management.

noise and confusion affect the decision-making process, and can undermine the most fail-safe technical systems.

Absenteeism and employee turnover are directly related to worker morale and overall health. 400 million lost workdays annually drains \$26.4 billion from corporate profits. High absentee rates occur in jobs with low pay, unpleasant work conditions, on night shifts and in the younger, less involved employee.

Heart disease alone accounts for 132 million lost workdays annually, and \$26 million in medical expenditures. Each of its known risk factors, other than genetic predisposition, is influenced by stress: Smoking, hypertension, hyperlipidemia, overweight, lack of exercise and the Type A personality. Again, the wage-waste incurred through absenteeism and employee turnover does not include the estimated six weeks that it takes to train a new employee to fill a vacated position or the down-time on expensive equipment.

"On-the-job absenteeism" can be even costlier. It includes negative attitudes, lateness, excessive breaks, daydreaming, errors and a high re-work rate. These workers are uninvolved, unmotivated and apathetic to corporate or divisional objectives. They are also more likely to be antagonistic to policy and procedural changes, cause friction in work groups, become abrasive bosses or insubordinate employees.

The implications for industrial risk management and loss control are apparent: employee motivation, satisfaction and health need to be improved, while absenteeism, equipment down-time and personal injuries must be reduced. Corporate productivity and profits are inextricably related to these variables. If the plague of the 1980's is stress, the challenge is to develop work environments conducive to individual health and corporate productivity.

Recent court decisions in about 15 states have awarded disability payments in cases where anxiety, depression or other problems have been caused by work stress. In California, claims have multiplied since the State Supreme Court upheld compensation for *gradual* on-the-job stress in a 1971 decision. The obvious question raised by this litigation is: How does one objectively measure occupational stress and evaluate its significance as an etiologic factor relative to the personality structure of the employee and his off-the-job stress? And a more fundamental question is whether it is possible to have productivity in a stress-free environment.

Stress and Productivity

The relationship between productivity and stress is illustrated in Figure 1. On the ascending limb of the curve, stress constitutes a positive, constructive force. The employee is motivated, performs within his capabilities and is recognized and rewarded for his accomplishments.

The bored individual at point "A" is underachieving and is likely to experience little job satisfaction. A recent Louis Harris Survey of 1,000 secretaries and clerical workers found that 74% of them felt they could do more in a day than they do now. They are not overstressed; they are not involved, and their performance efficiency is marginal.

The worker at point "B" is performing at a near peak level of efficiency. Though he may experience occasional stress due to deadlines, conflicts and work overload, his overall adjustment is healthy. The analogy can be drawn to a seasoned quarterback who executes a two-minute drill. He is under stress, but he has the training and ability to exert relaxed control under pressure. If the work conditions are favorable (having 3 remaining time-outs) he is likely to be able to achieve surprising results under the additional stress of a time deadline.

At point "C" the individual is on the descending limb of the Performance Effectiveness Curve. In this stress overload zone, he is experiencing frustration, anxiety and is likely to succumb to stress-related dysfunctions. He may resort to heavier use of alcohol or pharmacologic agents to quell his anxiety, in the mistaken belief that he can continue to work at a high level of activity. The overstressed employee's desk and mind may be cluttered with multiple projects and give the illusion of being a corporate asset, but on closer inspection his achievements are disappointingly average. Eventually, his stress overload results in a further reliance on substances, further deterioration in the quality of his home life, and at point "D" further decline in his output. In other words, his impressive flurry of activity amounts to a short-term gain that ultimately is taxed quite heavily.

Performance Effectiveness

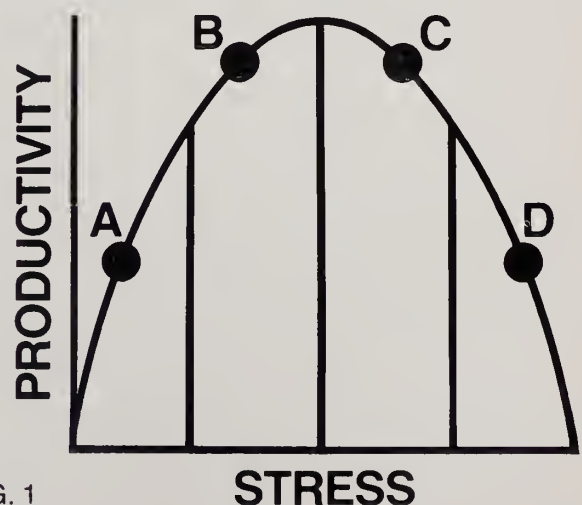


FIG. 1

Motivation and Job Performance

The most important management task in this century, according to Management Consultant Peter Drucker, is for institutions to learn to manage themselves for performance.³ It is imperative, then, to harness the motivational force of stress and eliminate or minimize the conditions that impair productivity. Research by experts such as Maslow, Herzberg, White and McClelland has contributed greatly to our understanding of employee motivation, and the interpersonal dynamics of organizational life.

Much can also be learned by looking at individuals in various occupations whose stress has been manageable and who succeeded in leading exceptionally long and productive lives. One can see proof of this in the lives of George Burns, Arthur Fiedler, Armand Hammer, Grandma Moses, Winston Churchill, Henry Ford, and Bertrand Russel. Clearly, it is possible to integrate a successful career and a healthy lifestyle. The essential ingredients are "control", "success", "satisfaction" and "recognition." The managerial lesson to be learned in improving employee productivity and health is to give people jobs they are capable and trained to do, that they really enjoy doing and that other people appreciate. Before this imperative can be translated into a cure-all formula, it is necessary to understand *why* people work, the impact of economic and social change on employee values and expectations, and the influence of non-work stress on our lives. This last factor is critical since each of us carries our "emotional baggage" to the office or plant and tends to bring the frustrations and stresses of work home.

The seemingly obvious answer to *why* people work is money. In fact, one definition of a job is something you are paid to do and probably would not otherwise do. It meets the economic conditions necessary for survival and creature comforts. But this only explains why people get a job, it offers no insights into why people *work*, or more precisely, *work harder*.

Clearly, many other needs are met through working. Some work for power and control, while others are motivated by a desire for recognition, challenge and achievement. At the present time, more than half the adult women in the United States are in the workplace. For many this has been an economic necessity, but for many others it has provided psychological support for their autonomy, and a badge of membership in society at large. At times we work as a refuge from the boredom or depression of our lives. Consider how people in grief regard work. It is not uncommon for someone to say that the only thing that kept him going was burying himself in his work.

Work provides each of us with a clearer definition

of who we are and where we are going. It is part of our identity. Upon meeting people we ask first their names, and then, generally, what they do. Work is the medium through which we measure ourselves, achieve growth towards our goals in a socially approved way. Without this sense of purpose there is unrest.

The Work Quadrangle

A worker's experience and attitudes are influenced by four inter-related systems. His productivity and/or stress at work are determined by the interactions of the systems comprising the "Work Quadrangle" (see Figure 2). Collectively these systems can contribute to an individual's self-concept and enhance his belief that he can achieve his goals. Alternatively, they may collectively undermine his feelings of self-worth, produce unmanageable stress and severely compromise his ability to perform.

Prevailing social and economic conditions are external factors that are beyond the individual's sphere of control. As such, they establish a context for his personal and work experience. Dr. M. Harvey Brenner, a professor at Johns Hopkins University notes that, "each increase in unemployment of one percentage point during a recession causes about 37,000 deaths over the succeeding six years."⁴ These deaths are attributable to cardiovascular problems due to stress and poor diet, suicides, homicides and cirrhosis. Not only are the unemployed at risk, but also the underemployed and many who just fear they will lose their jobs. In this context, coexisting stress on the job, in one's personal life or at home are magnified.

The Work Quadrangle

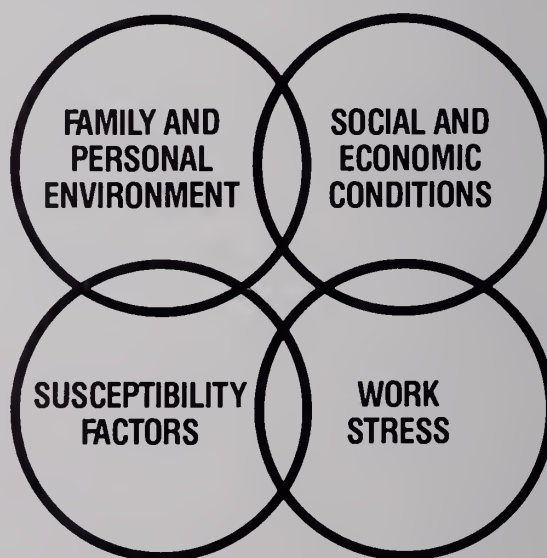


FIG. 2

Change in the Workplace

External factors are also influenced by management's attitudes towards its employees, and society's view of a particular job. For example, if society values a particular occupation and accords recognition and admiration, these can serve as powerful buffers to the everyday stresses experienced on the job. Conversely, if there is suspicion, resentment or ridicule of the particular job function or towards the organization, this tends to undermine the worker's efforts and beliefs about his self-worth. One can find examples of society's changing attitudes toward military personnel, policemen, correctional officers, physicians and politicians, as well as towards organization structures. For example, a utility company employee may be discredited or ridiculed by friends and neighbors because of the overall impression they have of his employer.

In 1790, nearly 90% of the United States population worked on the land. Today over 95% of the work force is employed in non-farm occupations. Many of these are in a high technology area where jobs and skills rapidly change. The more rapid the rate of technological innovation, the faster an individual's training and skills become obsolete. In medicine and the para-medical fields, for example, information has an extremely short half-life. Individuals are constantly under pressure to update their skills and adapt to changes or face the prospect of obsolescence.

Man has a limited biological capacity for adapting to change. When this capacity is exceeded, his work is carried out under a high level of stress, and his efforts become counterproductive. In my practice, I have seen an increased incidence of clinical pathology among executives and professionals in these "information explosion careers" who present with depression, various psychosomatic symptoms and irritability.

Nevertheless, change is essential for progress and growth. Without change there would be no research, new products, expanded markets, new customers or advanced techniques. But in order to successfully implement change without resistance or a high rate of errors during the transitional period, management must consider the impact of these technological changes on its personnel.

A second system in the Work Quadrangle encompasses an individual's personal values and relationships. These factors influence his work experience.

In the Horatio Alger story the hero works day and night to get ahead and everyone admires him. Employee motivation techniques under this American work ethic utilized the simple carrot and stick philosophy. In the 1950's an employer offered money and status as the sole reward for full-time work to the male breadwinner who

provided income to his intact nuclear family. Unfortunately, though the work ethic and people's values have changed, many corporate approaches to employee motivation are predicated on outmoded behavioral patterns. Today's worker is as concerned with his self-worth as he is with his net worth. For example, upwardly mobile executives are now refusing promotions that involve relocation.

Just when employers thought they had all the answers, the society of the 60's and 70's changed all the questions. This was an era characterized by social unrest, women's entrance into the workplace, the emergence of mass media, the decline of the family, spiraling divorce rates, consumer advocacy, inflation and the intrusion of governmental regulations. At the same time there was a growing public suspicion towards power, authority and leadership in general. The individual who was once committed to his job and eternally loyal to the corporation, became distrustful of institutions in general, including business, government, labor, the military and the family.

Today's employee wants his own individuality and potential to be recognized, and demands more control over decisions that affect his job and his opportunities for growth. He is more likely to have loose loyalties to a particular corporation, and even to a specific occupation. He is more concerned with the trade-offs he has to make as a result of his work. He may resent intrusions into his leisure time when he is forced to travel on company business on weekends. He is also concerned with having to sacrifice time with his family. According to a Wall Street Journal/Gallup survey, 80% of the chief executives of the 1,300 largest U.S. Corporations, "acknowledged that their family lives have suffered because of their careers . . . The regret mentioned most frequently: too little time with family."⁵ The challenge in the 80's will be to revise incentives and job stresses to match the values and motivational "go-buttons" of the New Worker.

Susceptibility

Susceptibility is the third system in the Work Quadrangle that determines where a person falls on the Performance Effectiveness Curve. Two factors in the individual's life are most important: his age, or more accurately, his stage of life, and his personality style. Each of these modulates his experience of work, non-work and external stressors.

An individual who is fired or laid-off from his job will experience distress regardless of his age. However, it is likely to be more traumatic for a 42 year-old than for a 28 year-old. In an era that overvalues youth and fears aging, the mid-life crisis can be particularly disturbing.

I refer to this phase as "The pause that depresses." The rising young executive on the "fast track" to the top finds himself at a plateau. He recognizes that his fantasies of rising to the top of the pyramidal hierarchy will never be realized. At the same time he is becoming aware of bodily decline and his own mortality. He is vulnerable to job stress, sensitive to economic fluctuations and may have a sense of stagnation about his marriage. He may lose interest in his work, abandon the corporation that does not "appreciate" him, or try to recapture his youth by having an affair. He may also present as a patient because he is depressed, drinking too much or experiencing cardiac or gastrointestinal symptoms.

Similarly, during the early to mid-thirties an employee may experience other life-stage related problems. He may be concerned with "making it" and be acutely aware of the tradeoffs he is being forced to make. For the first time he may have a nagging sense of having missed something. At the other end of the spectrum, retirement may be particularly difficult to negotiate for the individual whose whole life has centered around his work. Suddenly, he feels empty, as if the main cornerstone of his identity had been removed.

Type A Personality

The particular personality style of the individual also contributes to his susceptibility to stress. The "Type A" Personality described by Doctors Friedman and Rosenman⁶ experiences an unwarranted sense of time urgency, is polyphasic in his activity, is aggressively competitive, and carries twice the risk of coronary artery disease as his "Type B" counterpart. This is the person who keeps looking at his watch when he goes fishing. The Workaholic functions, and believes he thrives on, high levels of adrenalin and stress. On closer scrutiny his productivity is not proportional to his efforts, and certainly not worth the incurred risk of premature atherosclerosis. He tends to be abrasive to his superiors, peers and subordinates alike because of his intolerance, while his rigidity and hostile competitiveness make it difficult for him to have the negotiating skills required of the "team player." He lacks the patience to delegate tasks that could be handled more efficiently by a subordinate. Adding to these sins of mismanagement, he is unrealistic in setting deadlines, and tends to be overextended and over-committed because of the merciless demands he makes on himself. Not only is he under continuous stress, but the people who live with him and work with him pay a heavy price as well. Typically, he may state that he is "working himself to death for his family," but the workaholic generally is responding neither to family needs nor corporate objectives but to an internally generated set of compulsive drives.

A close cousin to the workaholic is the perfectionist. Whereas the workaholic's credo is "the more you sweat, the more you get," the perfectionist's motto is "no pain, no gain." Perfectionists desperately need to excel, to perform admirably, and therefore often set impossible goals for themselves. Their self-worth is measured entirely in terms of their accomplishments, or the realization that they are falling short of unrealistic ambitions. Consequently, these individuals frequently experience mood disorders, low self-esteem and have troubled relationships.

Their productivity is seriously impaired despite, or because of their lofty goals. They transfer their perfectionism to others and are highly intolerant of the shortcomings in family members or subordinates. Since they are convinced that a perfect result is mandatory, they cannot risk delegating any portion of a task. They cannot distinguish between excellence and perfection and so they will frequently procrastinate rather than risk making a mistake.

When they do perform, they experience heightened anxiety because of the added stress they place on themselves. If they experience continued frustration in their endeavors they become candidates for "burnout." This phenomenon was first described in the helping professions, but is present in other professionals and executives as well. The high achiever establishes unrealistic goals for himself, and experiences on-going frustration at not being able to measure up to his own standards. Though he may be exceeding everyone else's expectations, inwardly he considers himself a failure and feels that he is a sham.

At this point he may turn to a false cure to keep himself going in a last ditch effort to reach the impossible dream. Alcohol, stimulants, love-affairs, or a new job seem to offer some way of relieving his stress and fatigue. The burnout victim has now moved from point "C" to point "D" on the Performance Effectiveness Curve. The perfectionist who was reaching for the stars is now grasping thin air. With supportive counseling and the acquisition of effective self-management techniques, these potentially high achievers can learn to become more productive and to restore a sensible balance to their lives. Before the perfectionist can live up to his true potential he must overcome his fear of failure, and understand Mark Twain's definition of man: "a creature made at the end of the week's work, when God was tired."

The Success Syndrome

Another factor that may contribute to an individual's susceptibility to work stressors is "The Success Syndrome." Typically, an individual succeeds in achieving a long-sought-after goal: an aspiring middle management

executive becomes a Group Vice President. To everyone's amazement, including his own, he begins to slip into a profound depression. Just as he has moved up the ladder of success, he develops a growing malaise, and his achievement feels hollow to him. His work suffers, his family life deteriorates, and in severe cases the events culminate in a post-promotion suicide. The etiology of this problem lies in our ambivalence about outdoing our peers or our parents. The individual may sense a conflict between wanting to be liked by his former peers and the authority he must exercise in his new position. The promoted employee may also have a vague uneasiness, because his new visibility may make him a target for criticism and review. Furthermore, once one has become a success, there is the additional responsibility of continuing to be a success, much like trying to maintain an undefeated season. When the individual becomes aware of these conflicts and anxieties, the unexplained depression is less enigmatic.

Work Stressors

The final system in the Work Quadrangle are the specific work stressors found in particular occupations. Each job and each level in the organizational hierarchy has its own specific stresses. No job is stress-free and no individual is immune to its cumulative effects. The prevalent methods of coping tend to emphasize restructuring and redesigning job descriptions to relieve stress. These approaches generally fail to recognize the other contributing factors described by the Work Quadrangle.

There is another school of thought that proposes to teach the individual to manage stress by learning one of several popular relaxation techniques. The proponents of this approach are generally well-intentioned, but deal only with the end-results of stress rather than make any attempt to identify the causes and develop a blueprint for change. Of course, if an individual is injured, it is necessary to treat the injury and relieve the symptoms. But this is far from a comprehensive approach. How much more valuable it would be to identify the causes and risk factors and avoid repeated accidents in the future.

In order to accomplish this goal, work stressors must be seen in their proper perspective in the Work Quadrangle. External factors, individual values and beliefs, and personality characteristics affect the employee's tolerance for work stress, his health and his productivity. A partial list of the most common work stressors is found in Table 1.

An individual, particularly one who is perfectionistic, experiences stress as he perceives a widening gap between the demands of his role and his ability to meet those demands. Thus the person who is overpromoted or lacks the managerial skills required of a new administrative

Table 1. — Common Work Stressors

1. Overpromotion (Peter Principle)
2. Obsolescence
3. Poor Time Management
4. Ambiguous Roles/Vague Objectives
5. Policy, Process or Procedural Changes
6. Responsibility for People
7. Transfers
8. Executive Travel
9. Lack of Recognition, Responsibility or Growth
10. High Responsibility — Low Authority
11. Work-Group Conflict
12. Supervisory/Manager Conflict
13. Shiftwork/Boredom
14. Physical Factors, (Noise, Lighting)

function is likely to perform ineffectively. Similarly, the employee who is underemployed may feel that his true worth to the organization is not being recognized. His perceived ability exceeds the demands of his job. This may result in boredom, resentment and ultimately job turnover. In both cases, the individual is under stress and his potential productivity is compromised. Teaching these employees how to relax will not alter their underlying problem, or contribute one iota to their productivity. A comprehensive, problem-solving approach must identify these individuals, provide them with constructive performance evaluations, and give them the opportunity to acquire additional skills required of their positions.

Background noise, shift-work, executive travel and relocation all produce psychological and biological stresses. Each presents a specific risk that can be modified. For example, the executive who travels frequently on company business undergoes unique physical and psychological stresses that directly affect his performance capability. Though he is primarily a sedentary worker, periodically he endures long, tiresome flights through several time zones, rushing through airport terminals laden with 30 or more pounds of luggage. He may eat or drink to excess on the company's expense account and further impair his physical stamina. Thus, having performed more exercise than he has had in a month, and feeling fatigued, overfed and situated in an unfamiliar environment, he is expected to be at his peak level of performance when he represents the company. At the same time he may be concerned about a situation at home, or thinking about all the work awaiting him when he returns to his office.

Management needs to be aware of these impediments to productivity. The traveling employee or the relocating executive family undergoes acute physical and emotional stress. They must be provided with practical information and guidelines enabling them to anticipate and successfully negotiate these stresses.

Several work stressors in Table 1 relate to organizational conflict. It may exist within work groups, between employee and supervisor, between divisions, or in jobs that require interaction with the public. Conflict induces autonomic responses of the "fight or flight" type. When these hormonal reactions are chronically sustained, they are extremely damaging to the biologic system, as well as to organizational operations. Modern corporate structures require individuals who can provide decisive leadership, but who also have the ability to negotiate and resolve conflicts.

The individual with a strong technical background may require constructive skills and techniques for building cooperation, motivation and involvement. These are vital skills that most managers use poorly. Few corporations can afford to tolerate abrasiveness and poor leadership in deference to a manager's technical expertise. There are numerous examples from major corporations where high-ranking executives have been asked to resign primarily because of their inability to deal effectively with subordinates, peers or members of the board.

Medical Risk Management

Stress overload is a multidetermined phenomenon and can only be managed by an analysis of all of the etio-

logic factors. This follows the prescribed medical model of problem solving: an accurate diagnosis is mandatory before an appropriate therapeutic regimen can be implemented.

In my own experience as an organizational consultant I have found that a workshop offers an ideal setting in which to teach stress management and performance effectiveness techniques. Participants receive a portfolio of self-assessment inventories that relate to the risks and skills being presented. This enables the individual to identify his own strength and vulnerabilities in a non-threatening, non-punitive atmosphere. Equally important are the diagnostic data that emerge and serve as a needs analysis for the organization. Using this information, measures can be taken to correct deficiencies and maximize productivity through appropriate managerial planning. A risk management program should identify losses, and develop cost-effective programs designed to obtain peak productivity from personnel, at a reduced health and accident risk, and under an optimum level of stress.

References

1. The New York Times, January 11, 1981.
 2. Occupational Health and Safety, October, 1980.
 3. Drucker, P.F., *Management: Tasks, Responsibilities, Practices*, Chap. 14, pp. 158-166, Harper and Row, New York, 1974.
 4. The Wall Street Journal, Monday, August 25, 1980.
 5. The Wall Street Journal, Wednesday, August 20, 1980.
 6. *Type A Behavior and Your Heart*, Friedman, M., Rosenman, R., 1974, Fawcett Publications, Inc., Greenwich, Connecticut.
- Dr. Rosen, 3636 University Boulevard South, Jacksonville 32216.

Are Doctors Different?

Reflections on the Psychodynamics of Physicians

Glenn Golloway, M.D.

Abstract: Since phobic fears of suffering, disease and death play a large part in the selection of medicine as a career, a variety of emotional defenses are necessary among physicians. Objectivity toward diseases in others is made possible by these mechanisms. However, when the physician himself is ill, his protective defenses are threatened by the feelings of weakness, helplessness and danger that arise. His behavior as a patient results from efforts to maintain these defenses and is likely to be far from objective, since it strikes at the very fears giving rise to his career choice. When a physician treats a physician, objectivity may be further impaired because both share similar dynamics and thus tend to support each others' defenses. Denial of illness, in such instances, can lead to serious errors of omission in the health care provided to physician-patients.

Are there some things about being a physician that make all of us more vulnerable to certain types of psychological stress and render us less able to seek help or accept it when needed? From my experiences over the years in interviewing medical school applicants and in observing and treating students, house staff and physicians, I have been struck by the frequency with which certain psychodynamic themes appear to recur. It is as if there is a set of psychological characteristics, both brought into the profession by new students and shaped by their subsequent common experience, that are peculiarly medical and that account for much of our particular susceptibility to stress. Not all of these traits are present in equal degree in all physicians, nor are they necessarily implicated every time a physician gets into emotional difficulty. They do, however, help explain some of the unique psychological hazards that go along with the occupation.

As a profession, medicine can be both extremely enjoyable and rewarding as well as highly demanding and stressful. For some individuals, the stresses eventually come to outweigh the benefits. In trying to understand how these casualties occur, attention is often focused on the external demands and responsibilities that are in-

involved in clinical practice. Much less attention has been paid to the other side of the interaction: the special vulnerabilities of the practitioner. Some of these are discussed and examined below. The reader should be cautioned that the various factors outlined are only clinical impressions and have not been validated by means of more formal scientific scrutiny.

Motivations for a Medical Career

Most medical school applicants describe their motivation as stemming from a desire to blend their interest in science with a compassionate wish to help sick people. Identification with the victims of disease and suffering helps to prompt rescue fantasies. There is often a history of a family member, close relative or friend suffering and perhaps dying from a frightening illness while the family was forced to stand by, frustrated and helpless. The physician on the case was idealized, viewed as powerful and helpful, and believed to be able to counter the threat. He was seen as a good sort of person for one to be in the face of future threats from illness. In this fantasy, the emphasis is always on the victim being rescued and protected from suffering and disease, rather than being passively and helplessly subject to it. Most physicians are, if the truth were known, somewhat phobic about disease.

Other students come from families where a family member is a physician. If the physician is viewed positively, the growing child may model himself after him or her. Parents who work in the health fields and have

The Author

GLENN GOLLOWAY, M.D.

Dr. Golloway is Associate Professor of Psychiatry, University of South Florida College of Medicine, Tampa.

secret ambitions to be physicians, or who view physicians positively, are likely to pressure a child towards medicine. Physician parents themselves may try to make their children over in their own image but less often than one might think. The idea of excelling by identification or accomplishment provides pride and prestige in this group of motivations.

The motivation to help other people is often much less altruistic than it appears. A fantasy that the helped patient will always be grateful for the help is very often discernable. The helper gets to think of himself as better than, and better off than, the victim of the disease. He feels "one up." Such physicians often give patients what he thinks they want, rather than what may be medically indicated. These are bribes to get approval, and to show off the physician's power.

Many idiosyncratic and symbolic motivations are operative in career and specialty choices. For example, one physician experienced his patients as if they were carbon copies of his hypochondriacal complaining, critical mother whom he continually tried to pacify. He felt guilty over his resentment of his patients' demands and, in order to deny this, he was extravagant with his time and efforts to comfort and reassure. His self sacrifice produced a full practice, truly grateful patients, and high quality care in the best traditions of the profession. This example of sublimation illustrates that highly individual dynamic factors may also play a major role in determining career choice in medicine.

Anxieties Underlying These Motivations

Motivations about rescuing and being rescued imply underlying threats of injury of various sorts from evil villains presenting in the guise of suffering and disease. To be in the passive position in relation to the threats is to be helpless, vulnerable and endangered; hence passivity is itself to be feared. If someone is to be the cat and someone the mouse, it is a lot safer to be the cat. Yet we all "feel for" and identify somewhat with the victim in the submissive position, although safety comes when we identify with the aggressor. It gets more complex when we observe that diagnostic and treatment procedures are often not benign, and contain much aggression "done to" the patient. Being passive to the aggressions of treatment then results in a situation of ambivalence at least, and fearful avoidance or submission at worst. Admitting one's need to see a psychiatrist meets with even greater opposition because people tend to view themselves as guilty failures and fear their guilty secrets will come out in therapy, destroying their self-esteem and professional status just by virtue of seeking psychiatric assistance. Despite modern enlightenment, mental or emotional illness continues to carry greater stigma than physical illness.

Another feature that distinguishes physicians from non-physicians is the daily bearing of responsibility for life and death decisions. No other social group bears this responsibility so heavily. This keeps us in constant contact with the ultimate danger, and regardless of efforts to isolate our feelings, at some level constantly reminds us of our own mortality. This responsibility changes physicians and the way they do everything in life. Death is viewed by physicians as at least potentially postponable, so that every death is felt somewhat as a failure. It is feared and hated by us with a special passion, feared and hated enough for us to dedicate our careers and lives to endlessly battle against it.

Problems and anxieties about self-esteem trouble most physicians, although this may be difficult to discern because of compensatory behaviors. When physicians are held forth as ideals for children, the accomplishments that are aspired to may be seen as beyond reach. Self-esteem is related inversely to the distance perceived between present accomplishments and aspirations. Medicine can, however, never be mastered. As the goal is approached, it moves farther away as we learn how much more there is to know. The most that can be hoped is to stand well in a comparison with high standards and other physicians. Sibling rivalry among pre-med students is well known and persists into the profession. Feelings of not being good enough to handle certain kinds of responsibilities regularly help dictate specialty choice, both positively and negatively. To be "one down" in the competition reminds us of our shaky self-esteem.

Beneath the fantasies of endless patient gratitude are the fears of criticism and anger from our patients as they judge and monitor our actions and behavior. Aggressive and sexual impulses of any kind can readily lead to guilt, especially when we impart our patients with the power of knowing our darkest secrets. If we can please our patients, however, we get forgiveness. One physician hated to do rounds on Mondays or, even worse, after a long weekend, projecting his guilt and consciously imagining his patients to be reproaching him with the unspoken comment, "You were out there playing and having fun while I was in here suffering." Some physicians are workaholics hoping for patient gratitude to signal forgiveness from guilt.

Compensatory Traits

Compensatory personality traits develop to relieve or meet the anxieties discussed in the previous section. Varying in strength from physician to physician, they serve as defenses against the anxieties and conflicts involved in taking care of patients. Properly blended, they constitute a valuable emotional buffer for meeting the daily rough and tumble of clinical practice.

Knowledge of what to do, and the confidence to do it aggressively, usually prove effective in overcoming fears of death and disease. When taken to the extreme, these can lead to fantasies of omniscience and omnipotence. Exaggeration of the physician's sense of knowledge and ability help to reassure both doctor and patient. While it often may serve as a useful purpose for the physician to let the patient harbor such unrealistic views about his powers, it is never useful for the physician himself to share such distorted beliefs. Physicians who become seduced into believing that the M.D. degree has conferred some form of special, superhuman power on them, do not see the need to take care of their own health and well-being. They act as if they are invulnerable and somehow exempt from the ordinary human needs of rest, exercise, and relaxation. They neglect their own care and when they do fall ill, become very difficult to treat.

Matters of self esteem may be compensated in various ways. Enhancement of one's narcissistic view of self by taking a so-called ego trip is one way. Certainly, physicians are entitled to a little admiration and respect for much of what they do; the danger comes from over using this as a means of bolstering a self-esteem that is low for other reasons. Winning in a competitive encounter with colleagues is another compensatory mechanism that may be used as a means of boosting oneself. One needs only think of the critical comments offered after a paper is read at a medical meeting to remind oneself how widespread competitive behavior is in the profession. One-up-manship is very much with us. Perfectionism helps form a basis for competitive rivalry. It tends to keep things organized, accurate and constrained, and enhances the fantasy that we are really in control and not vulnerable. At times when the physician himself is needy, such behavior may easily serve to even further diminish his sense of self esteem.

When the Doctor is Sick

Having dedicated himself to an active battle against disease, both personally and professionally, a doctor who gets sick has a lot to lose. He must deal with at least a temporary defeat as well as with the enforced passivity involved in getting diagnosed and treated. Is it any wonder doctors tend to treat themselves, or submit only reluctantly and usually only partially to appropriate procedures and care? The tendency is to avoid the very health care procedures they recommend for others. A sense of failure and guilt may cause further avoidance behavior and denial. The sick physician may invite another physician to lunch to discuss a "patient's problem" using the luncheon as a peer relationship and avoiding a proper consultation relationship. He may even feel

that as host he is in the "one-up" position instead of the "one-down" position as patient. If competitiveness and sibling rivalry are prominent, the therapeutic relationship is further impaired since to be appropriately passive is to lose the competition.

Problems of the Treating Physician

One of the complications involved in the care of doctors is that the treating physician has all the same dynamics as the physician-patient. There is a special recognition by the treater of the narcissism of the patient: fellow physicians are to be treated with "respect" because we see ourselves in our physician-patients. We must maintain our own defenses, so we respect theirs. We tend to be very reluctant to place the physician-patient in the dependent role required for good care, because we ourselves dread that role or are scared off by their defensiveness. We may not insist on appropriate follow-up visits, collaborating in the fiction that the patient will care adequately for himself and return as needed. There are many horror stories about alcoholic or depressed physicians who have great trouble convincing the treater of the seriousness of their situation. Both the treater and the patient tend to collude in denial and, with bright physicians capable of skillful intellectualization, flight into health becomes easy and needed care is not provided.

This problem of denial is perhaps at its worst in cases of psychiatric illness and psychiatric hospitalization. Because we ourselves wish to have both our defenses and our professional status supported and not challenged or impinged, we are most reluctant to take a directly aggressive stance toward another physician. We tend to interpret such aggression as against the person even when it is in his behalf. This is especially so for psychiatric illness which is viewed as damaging to the physician's competence or reputation much more so than a broken leg or a heart attack. The Baker Act, which is the commitment law in Florida, has a many layered set of protections in which individuals may be held for protection without loss of competency or civil rights. Licensure review procedures for sick physicians have powerful protections provided for the practitioner. Despite these realities, the psychodynamic interaction between the treater and patient physicians produce far more efforts of omission than of commission. In psychiatric parlance, failure to protect a patient from his illness by proper treatment, including hospitalization or commitment when indicated, is a counter-transference problem of the treating physician. It tends to be based on over-identification with the patient and mislabeling aggressive action as against the patient instead of in his behalf. It is wholesome and proper to want to be sure such action is justified. We ought not to enjoy taking such action. But we

ought to do it when necessary, and do it willingly whenever not doing so would constitute neglect of our duty to protect the patient from his illness.

Easing the Strain

Here are a few suggestions then for handling these dynamics in the service of better treatment. Since both treater and patient share the same dynamics, much can be improved by awareness of one's own feelings. Consciously thinking about the narcissistic and defensive plight of the patient, as if you were in his position, can help "understand" his conflicting feelings. Letting the patient know that you appreciate some of the negatives about seeking help and following a treatment regime may lessen his anxiety. Showing respect for his wishes and

concerns, without really abdicating the leadership role, permits some reassuring collaboration and avoids the surrender of science to unrealistic defensive wishes. Power struggles signal fear and failure to enlist the healthy objective ego of the patient to the tasks. When drastic action is required, patients will almost always oppose; but if the need is great, at least a part of the patient's ego will usually recognize this. When the crisis is over, the patient almost always is truly grateful for treatment that was objectively decided upon, and firmly but sympathetically provided.

- Dr. Golloway, Box 14, University of South Florida College of Medicine, 12901 North 30th Street, Tampa 33612.



System Failure The Impaired Physician

Everet W. Witzel, M.D., Ph.D.

Abstract: The impaired physician is an impaired professional person, and as such reflects adversely upon the medical profession. Since many of the fine character traits (i.e. self-sacrifice, altruism, achievement orientation, and denial of personal feelings) that contribute to a physician's personal success can become risk factors for clinical depression with its varied manifestations (i.e. bad marriages, alcoholism, substance abuse, and suicide), it must be recognized that being a physician may be hazardous to one's health. Some claim that there is a disproportionately high rate of impairment among the members of the medical profession. If this is true, it would indicate system failure in regard to prevention of a serious problem. Who is responsible to deal with the impaired physician? His colleagues within the medical fraternity? The public at large? The government through its legislative branch? These questions and several others are addressed in this paper, as a few cries for help are analyzed, and examples of what is being done to curb this serious problem of the impaired physician are considered. Physician, heal thyself, must be considered a professional society's responsibility, for once a physician is impaired, he needs the assistance that must come from outside himself. We are our brother's keeper!

Caution: Being a Physician May Be Hazardous To Your Health

Practice Setting

Many of the fine character traits that contribute to physician success can become risk factors for depression. The majority of these qualities, i.e. self-sacrifice, altruism, achievement orientation, and denial of feelings, are adaptive for most physicians; therefore, expose them to clinical depression and its manifestations, i.e. bad marriages, alcoholism, substance abuse, and suicide. The depressed physician is burdened by an obsessive behavioral style that serves to ward off dependency feelings.¹

With three fourths of Americans using alcohol, it is not surprising that surveys substantiate that the incidence of drug addiction (including alcohol) and mental illness is high within the professional community — especially those individuals subjected to extra pressure and daily stress in an environment with easy drug avail-

ability and diminished careful supervision.² Physicians experience a rise in anxiety on assuming clinical responsibility. Therapeutic failure, diagnostic difficulties, and the death of young patients are the most stressful factors for practicing physicians.

In 1976 the *New York Times* published a series of articles regarding the problem of the incompetent physician. The *Times* claimed that as many as 16,000 licensed physicians, or 5% of the medical profession, were unfit to practice medicine, but it pointed out that only 72 physicians in the entire United States lose their licenses each year because of incompetence. However, the *Times* failed to mention in its series of five articles what American physicians are doing to help their colleagues. Nearly a year before the *Times* article, a major conference sponsored by the American Medical Association was held in San Francisco. Its theme was "The Disabled Doctor — Challenge to the Profession."³

A prospective study was done on 46 physicians and 79 controls who had been rated at college for their psychological stability and the quality of their childhood. Over the 30-year follow-up period, the physicians were less happily married and required more psychiatric treatment, with 36% of them admitting to high drug use as compared to 22% of the controls. Although these difficulties are often assumed to be occupational hazards of medicine, their presence or absence appeared to be strongly associated with life adjustment before medical

The Author

EVERET W. WITZEL, M.D., PH.D.

Dr. Witzel is Director of Medical Education and of Family Practice Residency at Florida Hospital, Orlando, and also Associate Professor of Family Medicine at the University of South Florida College of Medicine at the University of South Florida College of Medicine, Tampa. He is currently serving as Director of Health, Far Eastern Division, General Conference of Seventh-day Adventists, Republic of Singapore.

school. Only the physicians with the least stable childhoods and adolescent adjustments appeared vulnerable to these occupational hazards.⁴

Drug Addiction

Alcoholism and other drug dependency account for 85% of all physician impairment. This figure is bolstered by such findings as an increased physician death rate from liver cirrhosis, 40% of physician suicides being alcohol or drug-related, and over-representation of physicians in the narcotic hospital in Lexington.⁵

A study of more-successful-than-average physicians showed that 16% were drinking heavily by the time they were 46 years old. The equally successful nonphysician control group had a similar proportion of heavy drinkers.⁶ Is this related to the added stresses or to the social settings?

Suicide

Although there is no way at present to know the true incidence of physician impairment, a number of studies suggest that 10% of all physicians are impaired. The tip of the iceberg — proverbially speaking, is the fact that at least 100 physicians commit suicide annually. This is equivalent to the size of the average medical school graduating class.⁷

Epidemiological studies of suicide among American physicians have been highly contradictory. Since death certificates are frequently inaccurate, either to protect the family or for lack of toxicological evidence, there is no real good current method available to get the actual statistics. Although obituary notices in *The Journal of the American Medical Association* have been analyzed, at best they list only 50% of suicidal deaths as such. It was found that all health-care workers, e.g. nurses, dentists, and physiotherapists, were twice as prone to suicide as other professional workers — suggesting that contact with disease and death may well be a critical factor. Pharmacists and chemists also shared the increased risk, providing further evidence that access to drugs were utilized by 55% of physicians intent on killing themselves as compared to 21% of other suicidal Americans.⁸ It would appear that addiction is the major manifestation of psychiatric illness in physicians.⁹

Some of the isolated facts from studies on physician suicides reveal that (1) the two specialties with the highest incidence of suicide are ophthalmology and psychiatry, with psychiatric residents displaying an alarmingly high rate of suicide;¹⁰ (2) although the suicide rate for male physicians is the highest for those over 45 years of age, the incidence for female physicians is greatest below that age (consistent with reports of high rates of suicide among females in other professions);¹¹ (3) female physi-

cians appear to have a higher incidence of suicide (the psychosocial dynamics of their problems may well differ),¹² and (4) physicians tend to regard personal illness as weakness, a narcissistic injury which triggers defensive psychic regression and impairs reality — appreciation, allowing the doctor to deny a suicidal danger that would be quickly detected in a patient.¹³

Physician in Training

In a study of 40 sophomore medical students selected at random out of 80, which were given structured psychiatric interviews, six or 15% were psychiatrically ill. Anxiety symptoms did not increase in the preexam periods in the ill students; whereas the well students resembled “scared soldiers” as their anxiety symptoms approached those of the ill during these preexam periods.¹⁴ The psychiatrically ill medical students had a statistically significant incidence of positive family history of psychiatric illness that was markedly greater than that of the well students.

Evidence from personality tests of medical students and residents supports the concept for “developmental” changes in personality resulting from the professional socialization process. The expressive cluster accounted for 50% of the resident population but only 23% of the student population. The inhibited, compliant cluster accounted for 49% of the student population but only 29% of the resident population. This is consistent with the concept of progression; namely, a compliant student becoming a more independent, aggressive professional.¹⁵

A syndrome of dysphoria and impaired mentation afflicting young physicians has been described. This syndrome occurs at a time when the young physician's professional role is in transition and when he has just assumed increased clinical responsibility. Complaints include “memory lapses” in the clinical care of patients and a perceived lack of ability to remember recently read medical literature.¹⁶

One study of 53 residents who had just completed their internship in 1972 revealed that 30% of them had a depression during their internship. The onset of depression generally occurred at the beginning of their internship on a service with a higher number of working hours per week. Thirty-one percent of the depressed interns said that they would not choose medicine again as a career. With the depressed group, six had marital problems (who had never had marital problems before), four had suicidal ideation, and three had a suicidal plan. The depressed interns had a positive family history for depression and more previous depressions. The residents at the time of the interviews were in a variety of specialty residencies, medicine, surgery, pediatrics, ophthalmology, dermatology, radiology, and neurology.¹⁷

In 1975, the American Academy of Family Physicians Committee on Mental Health surveyed 325 family practice residency programs relative to impaired residents. Of the 233 programs responding to the questionnaire, more than 70% (164) identified impaired physicians, i.e. disabled by drug abuse, alcoholism, or emotional illness.¹⁸

A definite identity crisis has been recognized among first-year family practice residents as they rotate through the various specialty services. The residents tend to feel a primary responsibility to each service because of the long established tradition and heavy workload. Feelings of guilt result from placing the time spent at the model family practice center low among their priorities. The lack of adequate family physician role models during this first year experience heightens the identity crisis.¹⁹

The psychosocial factors seen as problems by family practice residents and their spouses are basically the same as those seen by all training professionals and are, for the most part, not unique to medicine. The central concerns are leisure/time scarcity problems, domestic/spouse complaints, conflicting demands on study needs, lack of self-confidence, reservations about medicine as a career choice, decrease in sexual expression, parenting worries, and communication deficiencies.²⁰

Analysis of the emotional problems of residents in psychiatry in the United States and Puerto Rico revealed that (1) the incidence of problems among women, foreign medical graduates, and residents from ethnic minority groups was no higher than would be expected on the basis of distribution within the residency population, and (2) a higher incidence of problems among younger residents and those who had transferred from other programs.²¹

Severe Stress: Cries for Help

Most of us know colleagues who have become entangled in alcoholism and/or drug addiction, and have personal physician friends who have committed suicide. All physicians are stressed but some cannot handle the stress as easily or as appropriately as others.

During the past several years, I have worked closely with a large number of family practice residents in a couple of programs. As one observes each of them make the transition from being a "dependent" medical student to an "independent" family physician, one can appreciate the tremendous stresses involved in this "adolescent period", i.e. approximately the first half of the three-year family practice residency. Since the "turf" identity is less distinct for a specialty of breadth, such as family medicine, the stresses relative to self-identity can be even greater for residents in these training programs.

Although the vast majority of family practice residents make the transition smoothly during these "ado-

lescent years of medicine", I have had to deal with approximately one serious challenge per year as director of 24 residents.

Assistance: Am I My Brother's Keeper?

If ever a group of people has felt the responsibility for answering the question, "Am I my brother's keeper?" in the affirmative, it must be the medical profession. Years of diligent educational preparation and of treating patients have imbued our profession with the motivation caring for our sick fellow beings. This is true for the physician and his practice and should be more true with his medical colleagues. Since most people are reluctant to seek help unless absolutely necessary, it is understandable that physicians with their medical knowledge are even more likely than most to treat themselves for minor ailments. They hope that recovery will ensue with minimal care and are especially reluctant to annoy colleagues with minor ailments — and are experts (like many patients) at denying the existence of anything serious until forced to face the facts. With alcoholism, drug dependency, and mental illness, the signs and symptoms are ignored even more often because of the prevalence of these problems. To complicate the picture, the more intense the suffering from these three illnesses, the less likely it is that help will be sought by the involved person.

Although the American Medical Association's Canons of Medical Ethics make it clear that physicians are duty-bound to help faltering colleagues, it is less clear how we are to do this. Medical schools and postgraduate medical education programs should be encouraged to (1) improve the skills of stress-handling techniques within the physician-in-training, (2) increase the awareness of the physician's vulnerability to emotional disturbance and the availability of help, (3) provide readily available psychiatric consultation and treatment, and (4) teach physicians to ask for help and not to treat their own illnesses or their family members.²²

A Gallup poll which surveyed the public's attitude toward medicine's self-policing indicated by a vote of 85 to 7% that the public approves of requiring the medical profession to take more effective measures to get rid of incompetent doctors.²³

The physical disabilities of the impaired physician, i.e. alcoholism and other drug dependency account for 85% of all physician impairment, are often dealt with by colleagues in a well-meaning but destructive cover-up. For example, a physician hospitalized to sleep off a drunk may be admitted under the guise of treating hypertension." Many physicians fail to view alcohol as a drug even though it is one of the most toxic psychoactive substances ingested by man. The fact that many physicians think there is no problem with alcohol is, in fact, a large part of the problem. The recognition of chemical depend-

ency in a colleague calls for an enlightened confrontation.⁵

Most state medical associations have developed programs for the impaired physician.⁷ Most operate as a statewide noncoercive program for locating, contacting and offering rehabilitative help to physicians who have become professionally impaired to varying degrees because of alcoholism, other drug dependence, mental, physical and aging problems, and/or medical incompetence. They function as a peer review organization and in some instances work in liaison with the state licensing boards.²⁴ Through experience, most programs now maintain that the confrontation aspect is very crucial to successful rehabilitation of the impaired physician. This must proceed with a colleague-to-colleague, compassionate atmosphere. The punitive approach is rarely successful.²⁵ Each state program has its own blueprint, but the Disabled Doctors Plan of the Medical Association of Georgia is an excellent example consisting of four major phases: identification, motivation, treatment, and reentry into the world of medical service.²⁶ Other methods and alternative approaches are being suggested in hopes of solving medicine's traditional problem, the "conspiracy of silence".²

The evidence reveals that the majority of physicians who develop a dependence on drugs tend either to become abstainers or to die.²⁷ This fact emphasizes the need to prevent dependence in the first place, thus also preventing some of the suicides by intelligent people. We need to ask the medical schools to reassess their selection process, i.e. now favoring persons with an obsessive-compulsive style of life which carries proneness to depression in midlife with the added risk of suicide. During the postgraduate training programs residents need to be encouraged to express their feelings and to stop projecting the image of "omnipotence" for the practicing physicians. During the professional career demands of patient care — with the immense responsibility of grinding endless work with frequent failure — must be controlled or the excessive burden will lead to emotional bankruptcy, depression and ultimately to suicide if alternative rewards are not fostered. The ambitious, driven physicians who overextend themselves are at risk, especially if suffering from chronic pain. We need to be aware of losses our colleagues are experiencing and look for depression during the year following the loss. Three to nine months after the loss is the period of highest risk. Any significant change in lifestyle may suggest a risk period.²⁸

Unfortunately some mentally ill physicians actually harm patients through direct involvement of the physician's symptoms. It has been observed that physicians are more likely than other professionals to remain in active medical practice although suffering from schizophrenia depression, severe neuroses, and personality disorders. Some distressful illustrations are summarized

in the literature.²⁹ The concern of "Am I my brother's keeper?" must include the molested and tormented patients by the mentally ill physician as well as the impaired physician himself.

As a colleague, it is important to deal gently with all problems related to the impaired physician. It is wise, where possible, to implement a system that places no stigma on any person. As a physician manager, it has been my policy to problem-solve with the impaired physician. I have found him more receptive to recommended course of action when involved in seeking the solution.

An example is the physician whose extracurricular activities began to hamper his patient care. In the privacy of my office, I gently but firmly informed him that he had tied my hands — figuratively speaking — by his recent activities; requesting him to help me select a peer review committee of physicians to investigate the problem(s). The following day he was informed that a month's leave of absence was being instituted, effective immediately. During this leave the committee was to function, rendering its findings and recommendations. He was also advised to see a psychiatrist, one mutually acceptable to him and the teaching chief in psychiatry, who would agree with the impaired physician's permission to furnish me a report of the prognosis for resolution of the personal problem(s) which in any way adversely affected patient care. This information was made available to the committee with a signed release by the impaired resident on file for such usage.

During the whole process, the impaired physician was reassured that all the physicians involved were his friends, which illustrates the true value of having the physician help select the physicians for his own peer review committee. Truth can afford to be fair! As long as one has the best interests of all parties in mind, we as physicians need to be as courageous in helping solve the dilemma of the impaired physician as we are in treating a malignancy. Both have their insidious beginnings, and their disastrous results.

As caring, compassionate physicians, we can be helpful to our colleagues in distress — and at the same time protect the public. We are our brother's keeper — whether or not we like to accept this responsibility.

The Law: Can it Protect the Public?

Pioneering effort in the development and passage of a statute addressing the problem of the disabled physician is attributable to the 1969 Florida legislature. Two years later, a similar act was passed in Texas. The American Medical Association's Legal Department prepared a model legislative statute applicable to disabled physicians borrowing freely from the state laws, particularly the Florida statute. The signal accomplishment of the

Florida statute was in its providing an alternative to the earlier punitive law. The 1969 statute emphasized measures for the treatment and rehabilitation of the disabled physician.³⁰

The so-called "Snitch Law" in New York State requires that any physician who is aware of misconduct on the part of another physician shall disclose such misconduct to the proper authorities, subject to being guilty of a misconduct himself if he fails to do so.³¹

In essence, this is already in effect in some states, for both California and Florida courts have ruled that in instances where a physician disabled by alcoholism has not been prevented from practicing, other involved physicians as well as the hospital are equally liable in the case of a malpractice suit. This now puts a legal responsibility on the colleagues of an alcoholic physician, which should make it easier for them to confront him with his problem and get him rehabilitated.³²

Several states have tried to strengthen the effectiveness of their medical disciplinary boards by requiring physicians to report unprofessional conduct by their colleagues and requiring hospitals to report cases involving restrictions on a physician's privileges. They have also guaranteed immunity for those who appear before peer review committees or report awards or settlements of malpractice claims to boards of medical examiners. Although there is a slight increase in the number of reprimands, censures, and other disciplinary actions, it would appear that the majority of impaired physicians continue to practice medicine.³³

There is evidence that a disciplinary and therapeutic plan for addicted physicians is effective, as observed in Virginia. Seventy-two percent of the 46 physician addicts reporting to the board from 1949-1974 were successfully rehabilitated and returned to medical practice.³⁴

Physician: Heal Thyself

As physicians we need to become more aware of the possible prodromata of a future "impaired physician".³⁵ Physicians need to foster efforts to improve self-awareness, tolerance of feelings, and coping skills for dealing with stress in themselves and their spouses.¹ Stress is a subjective phenomenon and is highly relative. It is closely related to our attitude and feelings. Although some feelings, i.e. inadequacy, are unjustified, their existence makes one feel incapable of coping with a given reality situation. This in turn, calls for a drink of alcohol or some other chemical for the sense of tranquility — if one is so inclined.³⁶ If one is made more aware of these pitfalls, a physician can better deal with the stress through attitudinal changes. The most important attitude to develop is a value for the "person" or "self" of the physician. For example, the first months of a family practice residency

are a challenge to the individual — as one acquires identity as a family physician. Role models help but one has to work out his own self-identity as an early step in diminishing stress.³⁷ For the family practice resident, an early meaningful relationship within the Model Family Practice Center will assist in acquiring his unique identity.¹⁹ Depression during the first year of postgraduate medical education can be lessened by decreasing the required working hours per week.¹⁷

The American Academy of Family Physicians Committee on Mental Health has developed a series of videotape vignettes designed for discussion of stress situations. These have been supplied to the Directors of Family Practice Residencies to help combat the stress most residents face during the long struggle of becoming physicians.³⁸

Physician attitudinal changes relative to alcoholism is best acquired by taking a two-week physician-training course in alcoholism in which emphasis is on direct, experimental contact between the physician trainee and the recovering alcoholic, i.e. daily group therapy experience as an active participant on an equal basis with the alcoholic patients. Didactic seminars without intimate patient involvement are practically useless. "A man is the sum of all the moments of his life, and his attitudes are the product of repeated experience."³⁹

Thank You: I Needed That!

Testimonials by rehabilitated physician alcoholics and the case examples given in articles on the physician drug abuser and the impaired physician illustrate the value of an aggressive program to combat the problems which produce disabled doctors.^{40 44}

Each of these salvaged physicians says "thank you" for the compassionate colleagues who thought enough of him as a person to confront him as an impaired physician setting him on the right track again. One freed physician drug addict summed it up nicely this way: "If you know of a colleague who has a major alcohol or drug problem, you can hasten his recovery by calling the disabled doctors program . . . I can assure you that you are doing him no favor by looking the other way. This approach might ultimately result in his death."⁴² Another ex-alcoholic physician wrapped it up thusly: "My life is now completely turned around. Now I am confident and competent in situations which previously would have frustrated me to the point of total helplessness. I am grateful to A.A. and a loving God for the opportunity to be that one in 37 alcoholics who does not die of his disease."⁴¹

Conclusion: Putting It All Together

Since we live in a very real world rather than an ideal

environment, everyone, including physicians themselves, needs to recognize that all the ailments afflicting the layman also touch the members of the healing profession. All the afflictions of affluence affect the physician himself. In the areas of stress, which affect members of all professions, the physician with clinical responsibilities is especially vulnerable. This becomes psychologically traumatic to physicians especially at the times of diagnostic difficulties, therapeutic failures, and the death of young patients.

Although the average medical student progresses relatively smoothly from being a compliant dependent learner to an independent, aggressive professional, there are a few casualties in the process of this professional socialization process. One study revealed 15% psychiatrically ill sophomore medical students.¹⁴ Another study of residents in their second year of postgraduate medical education found that 30% had a depression during their internship.¹⁷ Of these 31% said that they would not choose medicine as a career, given another chance to make the decision.

Unfortunately, the stresses of the practicing physician continue to affect some adversely so that the physicians with the least stable childhoods and adolescent adjustments appear vulnerable to occupational hazards, i.e. bad marriages, alcoholism, substance abuse, and suicide.⁴

The fact that more than 100 physicians within the United States commit suicide annually is a sobering reality, especially when one considers that it is equivalent to the number graduating in an average size medical school.⁷

With this "tip of the iceberg" evidence of a serious problem within the medical profession, it is appropriate that all the following measures be mobilized:

1. Improved counselling programs for undergrad-

uate students, especially at the time of their selection of a life's career.

2. Improved selection process for entry into medical school.

3. Improved counselling during medical school with appropriate personality matching of students for the chosen specialty.

4. Increased behavioral science teaching within both the medical school and the residency programs — teaching coping skills.

5. Compassionate but competent counselling for all impaired physicians, whether in private or within a training program.

6. Utilization of the punitive aspect of the law only as a last resort when all else fails to rehabilitate an impaired physician (i.e. confrontation with a colleague-to-colleague, compassionate atmosphere), or the patients are in jeopardy.

"Physician, heal thyself" is an ideal philosophy which has failed for those who need help most. It is time that we as a healing profession recognize that we must accept the responsibility for being our brother's keeper — especially our professional colleagues. Each of us needs help from time to time, and we dare not treat ourselves.

The very characteristics that appear to make us excellent physicians, i.e. self-sacrifice, altruism, achievement orientated, denial of personal feelings, are at times our biggest hazards leading to the development of clinical depression and its manifestations.¹

A balanced life is the goal to be achieved by all physicians if we as a profession are to remain healthy.

References available from the author upon request.

- Dr. Witzel, 800 Thomson Road, Singapore 1129, Republic of Singapore.

Update: FMA-FMF Impaired Physician Program

Guy T. Selander, M.D.

Over the past several years the *Impaired Physician* has been receiving much attention. All of us are aware of the multitude of stresses placed on a busy physician, as well as the easy availability of alcohol and drugs, because of the very nature of our profession, and our economic position. Though there are other physical and psychiatric impairments, the overwhelming majority of impaired physicians are inappropriately using alcohol and/or other drugs. For this reason, the FMA House of Delegates has limited, at least in its infancy, the FMA-FMF Impaired Physician Program to alcohol and other drug abuse.

For too many years the sick physician was ignored by his peers. The attitude was often that if we leave him alone, he will "shape up", and "straighten himself out". It is a lot of trouble to get involved in the personal and professional life of a colleague. Besides, no physician wants to jeopardize another physician's license and livelihood.

In 1969, Florida became the first state to enact a "sick doctor" statute. With the enthusiastic support of the Florida Medical Association, the Florida Legislature wrote the provision into the then existing medical practice act. This act became a model for other states, and in fact became the AMA's model sick doctor law. In essence, the new law authorized the Florida State Board of Medical Examiners to exercise any of a number of disciplinary options regarding physicians "unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition".

Prior to the sick doctor act, it required "misconduct"

by a physician to lift his license. This required *proof of fault* by a doctor, and almost required his breaking the law. The purpose of this act was, as I see it, twofold: To protect the public from the sick physician, primarily; and to channel this individual into the proper treatment, secondarily. No one could quarrel with either goal.

In 1975 Florida's nearest neighbor, Georgia, established the best known, and perhaps the most effective Impaired Physician Program. Under the dynamic leadership of the articulate and charismates Dr. G. Douglas Talbott, the Medical Association of Georgia's Disabled Doctors Program became, and is, the basic blueprint for other states. It is aimed at rehabilitation, not punishment.

During 1978-79, Dr. Ray Murphy, Chairman of the Committee on Membership and Discipline of the FMA, researched the matter of the Impaired Physician, upon instruction from the Judicial Council. At the 1979 Annual Meeting of the FMA, the House of Delegates adopted a resolution charging "the Board of Governors of the FMA with the establishment of an on-going statewide Impaired Physician Program". The FMA Board of Governors promptly approved President Hodes' appointment of an ad hoc committee composed of Dr. Joseph G. Matthews, Chairman, Dr. Vincent Corso, a member of the FMA Judicial Council, and Dr. Theodore Marshall, a Pensacola psychiatrist. The FMA Auxiliary appointed Marybeth Weigand as its representative, and its president, Edie Epstein also participated. Dr. Matthews and his committee met several times during 1979-80 and reported to the House of Delegates at its 1980 annual meeting. Following this meeting, President T. Byron Thames appointed the present committee, which has been working diligently to build on the excellent groundwork of the previous ad hoc committee. The Board of Governors showed its commitment to the establishment of this program by budgeting \$50,000 for the current year, in addition to the \$25,000

The Author

GUY T. SELANDER, M.D.

Dr. Selander is a family practitioner in Jacksonville, and is Chairman of the FMA-FMF Committee on Impaired Physicians.

earmarked for last year, much of which was supplied by the Auxiliary.

The FMA-FMF Impaired Physician Program is progressing slowly but deliberately. At present we have accomplished the following:

1. **Employment of a parttime medical director:** Dr. Dolores Morgan, director of the alcohol treatment facility at South Miami Hospital, has been retained.
2. **Installation of a telephone "hot line"** for reporting problem physicians.
3. **Establishment of liaison with the Department of Professional Regulation:** Cooperation with the State regulatory board is essential to the program's success.
4. **Presentation of the Impaired Physician Workshop** in January preceding the FMA Leadership Conference. This half-day workshop entitled "Paving the Road to Recovery" was attended by a standing room only crowd!
5. **The First Intervenor Training Program** was held in Miami on March 27-28.
6. **Program on Chemical Dependency at the FMA**

107th Annual Meeting is planned for May 1, 1981. Featured speakers will include Dr. Doug Talbott, program chairman of Georgia's Impaired Physician Program, and Dr. David Smith, Director of the Haight Asbury Clinic in California.

7. **Development of audiovisual program** including the film "Our Brother's Keeper" and the DCMA slide presentation.

The practice of medicine is a privilege, **not** a natural right of individuals. The medical profession has entrusted to it one of the highest callings in our society. Its general competence must be commensurate to meet that responsibility. The FMA-FMF Impaired Physician Program intends to identify the physician who is faltering, and to channel him/her into an appropriate treatment program — to rehabilitate this physician **before** his or her personal and professional life hits bottom. The program's success depends upon the support and participation of the FMA membership.

- Dr. Selander, 1736 University Boulevard South, Jacksonville 32216.

The Methodist Hospice Program

Clyde M. Collins, M.D.

Abstract: In recent decades, increase in knowledge related to the scientific aspects of the diagnosis and treatment of diseases has generated a system of increasing subspecialization and technology-oriented practitioners in the practice of medicine. This appears to have resulted in a loss of attention to something equally as important, the caring aspect of health care or the art of the practice of medicine. Fortunately, society and our profession have become concerned, showing a growing realization of the need to create a new and potentially important innovation in health care — Hospice programs. Such programs aim to provide organized, humane care to the terminally ill and their families combining medical aspects of care with emotional support. The philosophy of care in a Hospice program is to improve the quality of life of the patient and family by alleviating the pain; controlling symptoms; and recognizing that dying patients have special emotional, physical, social and spiritual needs that have to be met without actively prolonging life or accelerating death.

The opinions and philosophy expressed below evolved from a childhood spent in a Methodist parsonage, six years of hospital training, twenty-seven years in the practice of general surgery, episodic perusal of books and medical journals and nine months as medical director of a hospice, that provided loving care and support for over two hundred patients and their families, during that time.

The term "Hospice", derived from a medieval word used by less militant members of the crusades as places of shelter or refuge for their wounded companions, currently is used in describing programs designed to control and relieve the emotional and physical suffering of the terminally ill. Using as models St. Christopher's Hospice outside London and the Connecticut Hospice in New Haven, programs have been established in eight cities in Florida and more are in various stages of planning. While there are differences from one program to another, essential characteristics must be present if a particular program is to legitimately use the term "Hospice". Designed to supplement existing services, hospice, more than a program of medical care for the terminally ill, is an autonomous centrally administered program of coordinating home care and in-patient services. Physician directed, it is the art of medicine as practiced by the old horse and buggy doctor, performed in a multi-faceted fashion by an interdisciplinary team of nurses, social workers, physical therapists, psychologists, volunteers

and the clergy, all with the purpose of aiding the primary physician in providing modern palliative psychological, sociological and spiritual services to his dying patients as they are needed. Significantly different from the orthodox practice of medicine in which a patient is treated by a physician, the primary unit of care is not just the patient but the patient and his family, with services available on a 24 hour a day, 7 days a week basis, including the period of bereavement. Patients are accepted on the basis of their needs, rather than their ability to pay.¹

Conception

Some six years ago, Marcus Drewa, President of the Methodist Hospital Foundation and Hospital, inspired by a film on hospice at a convention, saw the need for such a program in Jacksonville. He persuaded his board that by developing a hospice at Methodist, the terminally ill patients in this area could be better served. Meeting Don Gaetz from Green Bay, Wisconsin, who had helped develop the Carl W. Kouba Hospice at Bellin Hospital there, he persuaded him to come to Jacksonville to assist in developing a hospice here. Rev. Ronald Mudd, full time chaplain at Methodist Hospital for many years and director of its Clinical Pastoral Education program, stimulated by the needs he observed in counseling families of dying patients, had also become interested in the hospice con-

The Author

CLYDE M. COLLINS, M.D.

*Dr. Collins is a surgeon, and Medical Director of the Methodist Hospice, Jacksonville. He is also an Associate Editor of **The Journal**.*

cept and was a logical person to help Mr. Drewa to get together a committee of physicians to discuss the implementation of such a program in Jacksonville. In 1979, the administration of Methodist Hospital, along with a committee of physicians investigated the feasibility of developing a better way of caring for the terminally ill patient and considered the hospice program as an option. The need for hospice services was discussed at length in order to devise a program format, staffing requirements and facility designs. A review of cancer deaths throughout the city was undertaken. Reviewing literature, communicating by telephone and letters with other hospices operating in the United States, the committee approved a plan to be comprehensive in design that would include in-patient, out-patient and home care services, allow admission to the program only through physician referral and be limited to no specific disease. The service areas selected were Nausau, Baker, Clay, St. Johns and Duval Counties — allowing hospice teams to function within an hour's driving distance of the in-patient unit.

When confronted with Methodist's desire to organize a hospice program, state health planners were perplexed, for no health systems plans in Florida addressed hospice care, no provisions were available for a hospice applicant to obtain a certificate of need, and planners and regulators were confused as to how or whether a hospice could be licensed in Florida. Methodist joined with Dr. Daniel C. Hadlock, then of Orlando and now President of the National Hospice Organization, along with Reverend Hugh Westbrook of the Miami Hospice to obtain health planning recognition of need for hospice services. A state hospice organization was formed and its members successfully persuaded the state legislature to pass the Florida Hospice Act, the first law in America officially recognizing hospice care, establishing it as a part of the health care system, and setting standards of performance for would-be hospices to meet. The law, based on the *Standards of Hospice Care* of the National Hospice Organization, passed both houses of the Florida legislature unanimously in 1979. In Florida today, hospices must obtain certificates of need and pass licensure inspections. Though additional effort is required, the intent of the law is to establish standards for continuous critical review and evaluation and to eliminate potential for abuse of the hospice system by limiting the risk of the dying from being exploited by profiteers abusing the hospice concept or by idealistic non-professionals untrained to maintain high quality of medical care.

Development

Ending an eighteen month period of planning and development, Methodist became the state's first licensed hospice in June of 1980. By then Gaetz had secured a

staff headed by Mrs. Donna Franzino, R.N. as patient-family care coordinator, Chaplain Mudd as psycho-social care coordinator, and the author, a former family practitioner turned general surgeon as part time medical director. Following the concepts of various hospices throughout the world, a program was developed by this team that would provide services to meet anticipated needs of potential hospice candidates. Criteria for patient acceptance were laid down. A model care plan was designed to include the relief of noxious symptoms of the illness, the freedom to be with families and friends in familiar, comfortable surroundings, the involvement in decision making about their care, the opportunity for honest and frequent communication, and freedom from heroic measures. Daily care was planned to keep the patient at home as long as appropriate with an understanding to help the patient work through his or her anger or depression, supplemented by help to the family before and during bereavement. In-patient facilities were designed to be cheerful and comfortable. In an 18 bed unit, rooms would resemble efficiency apartments, some of which would contain kitchens for families to prepare foods so that patients could indulge their culinary desires with as much freedom as in their own homes. The unit would be open to visitors around the clock. Children and pets were to be welcome. Dining rooms, dishwashers and clothes dryers would be available. Serving also as day care centers for ambulatory patients, ideally, in-patient facilities are needed in short term periods to initiate a skillful tailoring of the pain medication, to provide a few days respite to the family who has been laboring under extreme hardships for often long periods or when the family is unable physically or psychologically to care for the patient in his terminal few days.² It also serves as a temporary way station for patients without a home, until a more permanent domicile can be established. When admission to the in-patient unit is necessary, the patient and family are told that care will not include laboratory testing, diagnostic x-rays, vigorous treatment or life support measures except when necessary to relieve discomfort. Especially designed to provide a home-like atmosphere, in-patient facilities do much toward establishing confidence and relief in the dying patient, made possible by the attitude of the staff, the standard of nursing care and control of pain.

Suffering with partial intestinal obstruction, an emaciated elderly lady, whose entire left abdomen was filled with a matted mass of colon carcinoma, was cared for at home by her two daughters for four months with visits from our nurses. Vomiting for four days, she was admitted to the in-patient unit with complete intestinal obstruction. After a day or so like this, she agreed to having a naso-gastric tube passed into her stomach. Intravenous fluids, which we seldom administer, were begun. Nine or ten days later, she improved enough to have the N/G tube removed and the i.v.'s dis-

continued. Still very distended but existing on clear liquids by mouth and comfortable on hydromorphan (dilaudid) and prochlorperazine maleate (compazine) rectal suppositories, she was able to ho home and live fairly comfortably for six weeks on that regime before dying.

Referral of Patients

When a patient is referred by his physician into the hospice program, some member of the hospice team visits the patient to outline the hospice philosophy and concept. The patient and family are told that no further treatment directed against the tumor (or his terminal illness) will be undertaken but all care possible will be given as supportive treatment.³ A psychosocial assessment of the family, its financial support, all aspects of its cultural and behavioural patterns are carefully listed, as well as identifying and cataloging long term conflicts and tensions. Should the patient be rapidly approaching death, these problems often appear insurmountable but can be resolved through the involvement of various members of the hospice team when time permits. The medical director, in collaboration with the patient's own physician, makes an estimate of life expectancy and at a conference with the patient and his family, provides a detailed and honest prognosis. Doubt, hostility, depression and finally, acceptance are stages that all mortals experience when told of approaching death and each individual requires time to progress from one stage to another. The earlier the dying patient can be referred into the program, the more time is available for the hospice team to assist this progression as the patient goes through the valley of the shadow of death. The dying patient, becoming aware of the dwindling time available to share life with his or her spouse, children or friends, cries because of the approaching separation from those most loved, expressing the importance of the presence and frequent visits of family members and friends. Becoming less and less attractive, the fear increases of having others lose interest in him or her and as physical incapacitation increases, there is a growing sense of helplessness and loss of self esteem. One hospice patient wrote,

*To die is such a lonely thing.
We cannot take one friend along.
To hold a hand would make it
Far less a frightening song.⁴*

Referral by Physician

When the referring physician, believing that no further curative therapy can benefit his patient and decides to stop aggressive therapy, he then reaches the appropriate time to refer the patient into the program.

This is an extremely complex and responsible decision but confirmation from the program's medical director provides another opinion to the family, reassuring them that everything possible has been done to cure the disease. Extending life while increasing suffering or the risk of hastening death, makes the decision to further treat or not to treat the primary disease a profound one and involves every physician actively associated in treating the patient. When life saving measures are no longer appropriate, does this cancel the physician's contact with the patient? The physician, having attended the patient but aware that there is no hope for cure becomes unable to rationalize any scientific reason to maintain continuity of care for his patient. By agreeing to continue on with the patient, the true physician lends strong psychological support to the patient when he says, "I no longer can stop the progress of your cancer (or whatever the terminal disease may be) but with the hospice team, we can make your remaining days comfortable and we will be available and supportive." So whatever the patient's needs may be, hospice, a back-up program supplementing the care of the primary physician, aids the dying person by means of its multi-disciplinary team.

One elderly patient, with a borrowed felt pen,
wrote on a paper towel:

*"If it looks like I'm sleeping, come in anyway.
Call my name and we'll have a nice visit."*

She had this taped to the door of her
room which was always open.

Hospice Staff

The full time RN patient-care coordinator daily compiles application forms on every referral and with the chaplain and medical director accepts or rejects new patients. She coordinates the care plans weekly and oversees the day to day activities of all nursing personnel. Our chaplain, the spiritual leader and psychosocial coordinator supervises the activities of a full time volunteer director and a social worker, as well as organizes the bereavement program and memorial services. Four hospice RNs and two home health aides spend their days making home visits to between 30 and 40 patients monthly while ten RNs plus four LPNs and two nursing assistants are employed at present for in-patient unit staffing to care for some 7 to 12 patients daily. The hospice social workers, besides performing regular psychosocial assessment, play a key role in obtaining equipment and facilities for home care when the appropriate time

arrives for the patient to be moved from the inpatient unit to his home. A full time director of volunteers trains and schedules the work of volunteers who learn hands-on care alongside nurses, doctors and therapists and with the patient's clergy are accepted as respective members of the team.

The medical director, as everyone else on the team, must have a deep and abiding love and concern for mankind and be able to develop a warm, sympathetic rapport with every patient. He should be a perennial student and reader, not only of Sir William Osler's Aphorisms but of the Bible as well, for a religious background helps to commiserate with the dying patient and family. He must be willing and have the time to listen to and empathize with any member of the family in the patient's terminal days. He must be extremely sensitive to the patient's moods, needs and desires. He must have a knowledge of the natural course of malignant and terminal diseases plus the courage to debate his convictions with the referring physician when there is doubt as to whether the patient is or is not beyond the help of further curative therapy. He must have the authority to refuse inappropriate referrals. He must uphold and defend the reputation of his profession while constantly striving to elevate the art and quality of medical care in the hospice program and in his community. The medical director must be willing to make sympathetic visits to hospice patients wherever they are. In an unhurried visit "one should ask the patient about his pain, listen to his chest, do a gentle examination and then make recommendations for changes in management. Attention to the little details such as food, drink, bowels, position in bed and air in the room brings big emotional dividends. Above all, touch the patient, shake hands, take the pulse and gently palpate the areas of pain."⁵ The medical director, bringing discipline, experience and acquired wisdom to the hospice concept, nevertheless must be capable of treating each patient with dignity and compassion and kindness and with the intelligence and instinct that drew him initially to the profession.

Relief of Pain

The fear of inability to care for loved ones during sudden changes in the terminal stages of the disease and an inordinate fear of the use of powerful narcotics requires educating the family so that the patient may remain comfortable and die at home if he wishes. Pain medication, usually given by mouth, requires individual adjustment and often may require enormous doses. Chronic pain is extremely disabling but can almost always be relieved by analgesics alone or combined with tranquilizers which, selected properly, will allow the patient to remain alert and live as normally as possible. Cancer patients, convinced that their disease is fatal, have a

different concept of pain with anxiety and depression as major components.

In the early stages of the terminal disease, pain may be relieved by mild analgesics.⁶ Aspirin or acetaminophen should be tried first then mixtures of one of these with codeine or its analogues or pentazocine (talwin). When this no longer relieves the pain, morphine sulfate, which in addition to its analgesic affect tends to relieve associated anxiety and tensions and prescribed by mouth, but requiring 2 to 3 times the parenteral dose, is a most useful drug. Initially, our "Brompton Cocktail"

The goals of hospice are:

- To keep the patient home as long as appropriate
- To maintain and strengthen the relationship between the patient and his personal physician
- To elevate the quality of medical care for the terminally ill
- To educate health professionals and the laity
- To supplement and not duplicate existing services
- To support the family as the unit of care
- To help the patient live as fully as possible
- To keep costs down
- To provide to everyone a dignified and pain-free death.

was given in a 20 ml dose and contained 5 ml of ethyl alcohol, 5 ml of cherry syrup, 5 ml of prochlorperazine maleate (compazine) syrup and from 5 to 30 mg morphine sulfate depending on the severity of the pain. Some of our patients complained that it burned their throats so we took out the alcohol. Some objected to the sweet taste and we removed the cherry syrup. For some, the prochlorperazine was too much of a sedative and for them, this was omitted. So, although we still use a "Hospice Mix" containing morphine, prochlorperazine and cherry syrup, we often give morphine sulfate alone.⁷ Morphine tablets, not the cheapest but very effective in our patients, can be used along with prochlorperazine tablets or suppositories given concomitantly or as needed. A morphine sulfate solution, unflavored, is available in some pharmacies and is more economical than our Hospice Mix. When morphine doesn't relieve the pain, we often switch to methadone which has a half life of 25 hours and accumulates on repeated administration so debilitated patients and the elderly should be watched closely when this is given.⁸ Should the patient vomit, hydromorphan (dilaudid) rectal suppositories are available but also is obtainable in tablets for oral administration.

No one drug or combination of drugs is likely to relieve every patient with chronic pain. Not only may different combinations be required for patients suffering different kinds or degrees of pain but every patient may

require changes in medication at various times as pain becomes more severe as his disease progresses. While remembering the side effects of narcotics are constipation, respiratory depression, suppression of the cough reflex and mental cloudiness, do not forget that the purpose is to relieve pain and this requires frequent adjustment of dosage until it is accomplished. After determining the required dosage of a narcotic to keep the patient comfortable, this should be given on a regular schedule so as to erase the memory of pain. In treating pain with narcotics, physical dependence does not appear a problem, physiological addiction is rare and tolerance does not pose a clinical problem.⁹

One of our patients, a former alcoholic who had bronchogenic carcinoma metastasized to the dorsal and lumbar spine, was alert and pain free only after his medicines were gradually increased to 30 mg of morphine every four hours, 20 mg of methadone every 6 hours and 10 mg of compazine every 8 hours.

Assessment of pain is essential before planning any drug regime and the physician must be experienced enough to measure each patient's own unique awareness of pain, its intensity, its site, whether it is affected by body activity and whether it may be due to the carcinoma or to some other chronic disease which would respond to other medications. Careful adjustment of dosage will keep pain and discomfort to a tolerable minimum so that the patients may enjoy the benefits of pain free survival and face death in the presence of their families while mentally alert. A strong personal bond between the physician and patient can do much to ease the emotional suffering that accompanies chronic pain.

Team Care

At a regular weekly conference, the plan of care for all problems besetting each dying patient and his family is reviewed by the hospice team. Everyone is invited, including the patient, his family and his clergy, his own physician and the volunteers. Details of the patient's condition are given by the primary nurse who has been seeing the patient in his home as needs demanded in the preceding week. Everyone present may give his or her thoughts as to a solution to all problems, putting the patient's best interest foremost, so that every day of those few remaining to him will be as full of joy and pleasant experiences as the hospice can make them.

The primary burden of patient care falls on the nursing staff, providing a challenge to that profession and the medical community as well. Every member of the nursing staff must learn how the patient wants to be treated rather than how the nurse thinks the patient should be treated. This entails an unhurried visit, using imagination and attention to details, taking time to per-

form tasks such as feeding the patient, learning the patient's mode of communication and understanding when the patient cannot speak, or does so with great difficulty. Attentive listening, being sensitive to the patient's moods and taking time to decipher each remark are all important as well as learning to sit quietly with the dying. Developing a close relationship with the patient and all family members and continuing this after the patient's death requires a dedicated, mature, compassionate and understanding individual. To do this, each member of the staff must get to know well the patient and his family. Should one team member be indifferent, callous or uncomfortable around the dying or unwilling to work as a team member, the program will not sustain the patient's confidence. An artful blending of first rate nursing care and skillful use of drugs, in a climate of trust and support, communicates to the patient as words might not, that he or she will not be abandoned in dying.

Hospice Precepts

Hospice philosophy re-affirms life but exists to provide support and care for persons in the last phases of incurable diseases so that they may live as fully and as comfortably as possible and able to accept death without loss of dignity. Hospice recognizes death as a normal part of life yet hospice neither hastens or postpones death. Hospice exists in the hope and belief that through appropriate care and promotion of a caring community, sensitive to their needs, terminally ill patients and their families may be assisted in attaining a degree of mental and spiritual preparation for death that is satisfactory to them. Hospice helps patients live until they die and "if one believes in a soul that endures beyond one's body, the manner of one's dying might be the most important act of life."

Some of our patients have no religious beliefs, some are not affiliated with any church, but upon their death, most of the families request a funeral service. Here, our chaplains have a unique opportunity, not just to make spiritual conversions but, if there is any continuity in the human thought system, to help the family and friends develop it and so help the living to go on.

Continuity of care, now no longer for the patient, is still needed for the family. In contrast to acute illness, where recovery is expected, terminal illness in a family affects every member. The adjustment to life without the patient begins before death, becomes more difficult afterward and challenges every hospice team member with its professional treatments and guidance to assist in such resolutions. As Madre Maria contemplated years ago, "There is a land of the living and a land of the dead and the bridge is love, the only survival, the only meaning."¹⁰

Hospice Future

Before we can rationally determine the role of hospice in any health care program, we must fully understand the program's conceptual underpinnings, its current status and its future directions.¹¹ What is it about hospice care that takes it beyond other traditional concepts? Is it simply the attempt to organize care and purposely involve the family that makes this innovation unique, or is there more to understand? While each hospice program is linked by common concepts, the manner in which they are staffed, the range and depth of their services and the nature of their relationships with other organizations varies considerably. For example, today, hospice programs take the form of hospital based units, freestanding facilities, and expanded home care programs. Yet, we must precisely define hospice programs so that reimbursement by third-party payers can be arranged on a rational and equitable basis and to create standardization of staff organization to enhance the quality of patient care and the efficiency of operation. While having an apparent solid base of principles and a consensus of concept, it is clear that there is less than full agreement that the current hospice care movement represents the best way in which to deal with the needs of the terminally ill and their families. Care must be taken not to develop hospice care standards that would result in stifling innovations in the field. How can such a program enhance the quality of hospice care and can it be conducted at a reasonable cost? The future of hospice depends on public acceptance of its approach to service the needs of the terminally ill and their families, successful demonstration of the consistent provision of high quality care and the predictable availability of third-party reimbursement.

From this, it is hoped that we can gain better insight into the prospects for an appropriate role in a field that offers so much promise for providing the necessary support to a growing and neglected segment of our society. As the concept gains acceptance and programs multiply, our profession should not stand idly by but rather should we join with other segments of society to develop, work for, and direct this much needed aspect of caring for the ill.

References

1. Markel, W. M.: The Hospice Concept, American Cancer Society Professional Education Publication.
2. Saunders, Cicely: Hospice Care, *The American Journal of Medicine*, Nov. 1978, pp. 726-728.
3. Potter, J. F.: A Challenge for the Hospice Movement, *NEJM*, Jan. 3, 1980, Vol. 302, No. 1, pp. 53-55.
4. Norton, Janice: The Treatment of a Dying Patient, 1963, *The Psychoanalytic Study of the Child* — 541.
5. Demphy, J. Englebert: Annual Discourse — On Caring for the Patient with Cancer. *NEJM*, Aug. 5, 1976, Vol. 295, No. 6, pp. 313-319.
6. Moertel, Charles G.: Treatment of Cancer Pain with Orally Administered Medication, *JAMA*, Nov. 28, 1980, Vol. 244, No. 21, pp. 2448-2450.
7. Eastman, Margaret: Shattering Myths About Hospice Care, *American Pharmacy*, Vol. No. 518, No. 12, Nov. 1978, pp. 20-21.
8. *AMA Drug Evaluations*, 4th Edition, 1980, pp. 55-85.
9. Twycross, R.: Clinical Experience with Diamorphine in Advanced Malignant Disease. *Int. J. Clin. Pharmacol.* 7:198, 1974.
10. Wilder, Thornton: *The Bridge of San Luis Rey*, 1927.
11. Affeldt, J. E.: How the JCAH Views Hospice Care, *The Hospital Medical Staff*, June 1980, pp. 11-14.

Acknowledgements

This paper would never have gotten into print without the friendship, advice and support of the dedicated staff and volunteers of Methodist Hospice, Mr. Don Gaetz, my secretary Mrs. Joni Wood and Mr. Drewa, who made it all possible.

- Dr. Collins, 580 W. 8th St., Suite 6015, Jacksonville 32209.

This publication is available in microform.



University Microfilms International

Please send additional information for _____
(name of publication)

Name _____

Institution _____

Street _____

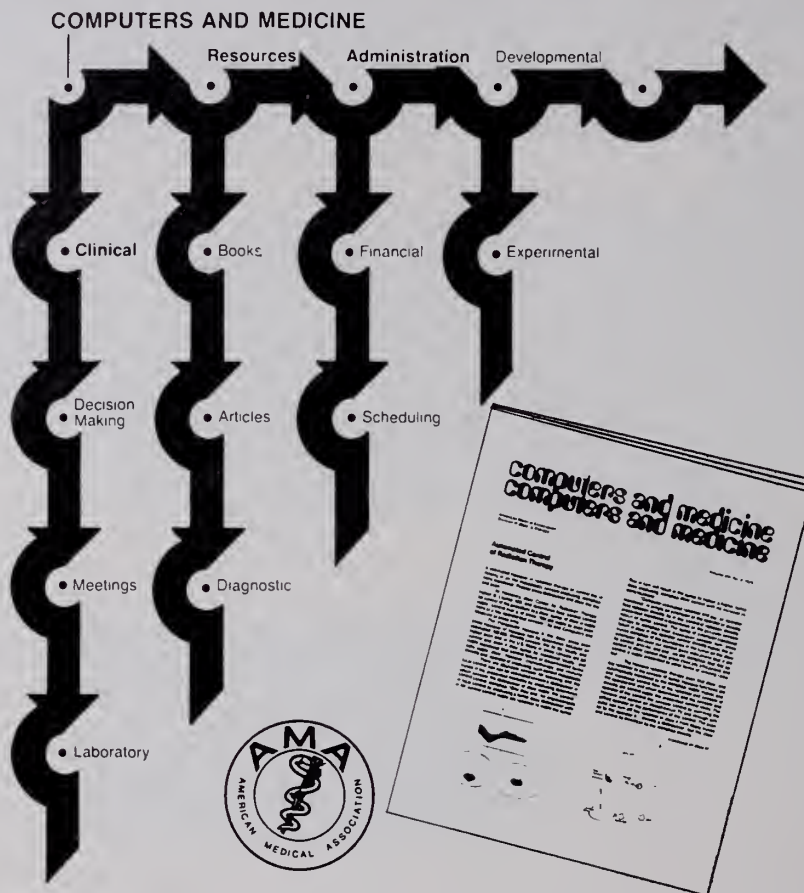
City _____

State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

Plug into the medical computing information network!



This bi-monthly publication is an invaluable source of information on the latest developments in medical computing technology. Produced by the AMA Computer Systems in Medicine Program, **Computers and Medicine** reports on the ways computer technology is used clinically and administratively in private practices, hospitals, clinics, and medical societies.

The format of **Computers and Medicine** emphasizes brief articles which convey the fundamental concepts involved in applications currently in use, as well as those in developmental and experimental stages. Information on whom to contact for more details is also included.

Plug into the medical computing information network; subscribe to **Computers and Medicine** today!

Subscriber Services
American Medical Association
535 N. Dearborn St., Chicago, IL 60610

I wish to subscribe to **Computers and Medicine** for the period indicated below. Enclosed is my check (payable to AMA) for \$ _____

☐ **1 year subscription, 6 issues** ☐ **2 year subscription, 12 issues**
\$12 U.S. and U.S. Poss. \$20 U.S. and U.S. Poss.

Name _____

Address _____

City/State/Zip _____

ORGANIZATION

Sen. Hatch to Speak at Annual Meeting

Sen. Orrin Hatch (R-Utah), Chairman of the Senate Labor and Human Resources Committee, will address the Annual FMA Auxiliary/FLAMPAC Luncheon on Friday, May 1, during the 107th Annual Meeting of the FMA at Hollywood.

Sen. Hatch's remarks will be preceded by a special presentation on "Epcot Center" at a general session earlier in the day. FMA President T. Byron Thames, M.D., has arranged the presentation in cooperation with Walt Disney World Officials.

Also scheduled to appear during the annual meeting

is author and lecturer Bjorn Secher, who will be the keynote speaker for the FMA Auxiliary's House of Delegates on Thursday, April 30.

FMA-A/FLAMPAC Luncheon

Sen. Hatch holds a number of key positions in the Senate. He is a member of three sub-committees; Labor, Alcoholism and Drug Abuse, and Employment and Productivity. As Chairman of Labor and Human Resources, he has oversight responsibility for the Departments of Labor, Health and Human Services and Education.

Apprenticed as a teenager into the AFL-CIO as a metal lather, Sen. Hatch worked his way through undergraduate and law school. He received a Bachelor of Science degree in history and philosophy from Brigham Young University in 1959 and was awarded a full honors scholarship to the University of Pittsburgh Law School. He earned the Juris Doctor degree in 1962.

Tickets for the annual FMA-A/FLAMPAC Luncheon will be available for \$16.00 perperson at the FMA registration desk at the Diplomat Hotel.

EPCOT Presentation Arranged

Epcot (for Experimental Prototype Community of Tomorrow) will open October 1, 1982. It will feature two theme areas, Future World and World Showcase.

The \$800 million project will cover about 600 of nearly 28,000 acres in the Walt Disney World vacation resort. It is the largest project ever undertaken by the Disney organization, and is expected to host eight to ten million guests during its first year. Walt Disney World has already entertained more than 115 million guests since opening in 1971.

Epcot Center will combine future technologies with Disney entertainment skills on a scale never before possible. It will include participation by major corporations and countries from around the world.



Sen. Orrin Hatch

The present Walt Disney World Magic Kingdom is 2½ miles north of Epcot Center, and will be linked to it by monorail. The new project will also include its own parking, service and transportation facilities.

Epcot Center is the continuing realization of Walt Disney's great dream for a community of creative concepts for the future where the best ideas of industry, government and academia can be showcased together.

New technologies and prototype concepts have been incorporated into Walt Disney World since the earliest planning more than 15 years ago and throughout Phase I — the Vacation Kingdom. Included are new transportation, communications and safety systems; solar and biomass energy experiments, and innovative master-planning and agricultural developments.

It will be as far advanced from the Disneyland concept as Disneyland was from the old-fashioned amusement park," said Card Walker, Chairman of the Board of Walt Disney Productions.

"In Epcot Center, the 21st century will begin Oct. 1, 1982," he said. "Like all of Walt Disney World," Walker added, "Epcot Center will always be in a 'state of becoming,' changing and presenting new ideas in dramatic

ways to showcase the technological advancements of tomorrow's world."

Bjorn Secher Keynotes FMA-A Activities

Mr. Secher is an authority on personal development and is also the originator of several management and sales achievement programs.

Another national figure taking part in the Auxiliary program will be Mrs. Harry S. Dvorsky, President-Elect of the AMA Auxiliary. She will install the 1981-82 FMAA officers.

A member of the AMA Auxiliary Board of Directors since 1975, Mrs. Dvorsky has served the national auxiliary as a project bank counselor, long range planning committee member, Western Regional Vice-President, and First Vice-President. She has also been a member and chairman of the national membership committee. Mrs. Dvorsky will take office as AMAA President in June of this year.

At the installation ceremony, Mrs. Francis C. Coleman will take the FMAA gavel as president from Mrs. Fred P. Swing.

Annual Meeting Scientific Program Offers 20 Hours of Free CME Credit

More than 40 separate educational programs will be available to physicians attending the 107th Annual Meeting of the Florida Medical Association beginning late this month. And the 20 hours of American Medical Association Category I Credit and FMA Mandatory Credit that can be earned will not cost FMA members a cent.

The sessions will get underway on Wednesday afternoon, April 29, and conclude on Sunday, May 3. There is no registration fee for members of FMA or the American Medical Association. The meeting will be housed at Hollywood's Diplomat Hotel.

"Stress and Lifestyle" is the theme of this year's program. This will be highlighted at a General Session on Stress and Lifestyle on Thursday evening, April 30, at which the speaker will be Joseph B. Trainer, M.D., of Portland, Ore. His topic will be "Stresses of the Medical Family."

CME Credit

As an organization accredited for continuing medical education, the Medical Education Committee of the Florida Medical Foundation has agreed to co-sponsor the program and designate it as meeting the criteria for 20 hours of AMA Category I Credit.

In addition, the Florida Academy of Family Physicians has approved certain elements of the program for AAFP Prescribed Credit. These include: the Thursday evening General Session on Stress and Lifestyle (1 hour); the Thursday afternoon Section on Family Practice (3 hours); the four "Dialogue" programs (1 hour each); and the Programmed Instruction System using the Auto-Tutor® (1 hour each program).

Well-Balanced Program

This year's program will be well balanced in terms of both scientific content and time distribution, according to Calvin W. Martin, M.D., of Arcadia, Chairman of the Annual Meeting Program Committee.

Wednesday afternoon will not be the exclusive domain of the Section on Internal Medicine as in recent years. Physicians seeking alternatives will find also on Wednesday afternoon a fine Section on Pediatric Cardiology and Neonatal-Perinatology.

A very good selection of activities will be available for the remainder of the scientific program on Thursday

afternoon (7 programs); Friday morning (8 programs); Friday afternoon (9 programs); and Saturday (12 programs).

Special Programs

In addition to 32 sections sponsored by FMA-recognized specialty groups, there will be four hours of "Dialogue" sponsored by Pfizer Laboratories (two on Thursday afternoon and two on Friday morning); a Section on Chemical Dependency sponsored by the Florida Medical Foundation Committee on Impaired Physicians (Friday morning); two Medical Malpractice Prevention Seminars sponsored by the Professional Insurance Management Company (PIMCO) (Thursday afternoon and Friday morning); and a Basic Life Support Certification course (Thursday afternoon).

Malpractice Prevention

Physicians who have their professional liability insurance with the Florida Physicians' Insurance Reciprocal are required to attend a Medical Malpractice Prevention Seminar during 1981. Physicians attending the Annual Meeting will have an excellent opportunity to satisfy this requirement.

PIMCO is conducting two of these seminars during the Annual Meeting. The Thursday afternoon session is billed as the Section on Orthopedic Surgery and will be especially tailored to the risks encountered in that specialty. The Friday morning session will be of a general nature. Physicians may satisfy the requirement by attending either irrespective of what specialty they practice.

Exhibit Hall

Physicians attending the meeting are strongly urged to visit the Exhibit Hall regularly. The Hall will feature more than 25 educational and scientific displays covering such subjects as Sudden Infant Death Syndrome, spinal cord injury, and treatment of ear diseases.

The Exhibit Hall also will house the Wyeth Auto-Tutors® by which individual physicians can view packaged programs on more than a dozen subjects.

The remainder of the Exhibit Hall will be devoted to the Auxiliary Art Exhibit and the technical exhibits by which physicians may update their knowledge on certain medical instruments, drugs, etc.

Here is the sectional program:

WEDNESDAY AFTERNOON, APRIL 29

SECTION ON PEDIATRIC CARDIOLOGY AND NEONATAL-PERINATOLOGY

(Co-sponsored by Florida Association of Pediatric Cardiologists and
Florida Society of Neonatal-Perinatologists)

1:00 p.m. to 4:15 p.m.

Wednesday, April 29

Jeane McCarthy, M.D., St. Petersburg

Program Chairman

"Bedside Use of Ultrasound in the Neonatal Intensive Care Unit"

— Hugh Allen, M.D., Teaching Scholar of the American Heart Association, and Professor of Pediatrics, and Director of the Echocardiography Laboratory, University of Arizona Medical Center, Tucson, Arizona.

"Prostaglandins: An Overview" — Jeane McCarthy, M.D., Ph.D., Neonatologist, All Children's Hospital, St. Petersburg.

"Palliation of Congenital Heart Disease with Prostaglandins" — Art Pickoff, M.D., Assistant Professor of Pediatrics, Division of Cardiology, University of Miami School of Medicine, Miami.

"Prostacyclin and Persistent Fetal Circulation" — Willa Drummond, M.D., Assistant Professor of Pediatrics, University of Florida College of Medicine, Gainesville.

SECTION ON INTERNAL MEDICINE

(Co-sponsored by Florida Society of Internal Medicine and Florida
Region, American College of Physicians)

1:00 p.m. to 4:15 p.m.

Wednesday, April 29

Roy H. Behnke, M.D., Tampa

Program Chairman

"Stress As a Component of Disease"

"The Dynamics of Stress" — Anthony J. Reading, M.D., Professor and Chairman, Department of Psychiatry, University of South Florida College of Medicine, Tampa.

"Asthma" — Samuel C. Bukantz, M.D., Professor of Medicine, Division of Allergy and Clinical Immunology, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

"Hyperventilation Syndrome" — David A. Solomon, M.D., Associate Professor of Medicine, Division of Pulmonary Disease, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

"Hypertension" — Celso Gomez-Sanchez, M.D., Associate Professor of Medicine, Division of Endocrinology and Metabolism, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

"Acid Peptic Disease" — Heinz Juergen Nord, M.D., Associate Professor of Medicine, Division of Digestive Diseases and Nutrition, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

"Functional Bowel Disease" — H. Worth Boyce, M.D., Professor of Medicine, Division of Digestive Diseases and Nutrition, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

"Dermatologic Stress Related Disorders" — Neil A. Fenske, M.D., Assistant Professor of Medicine, Division of Dermatology, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

THURSDAY AFTERNOON, APRIL 30

DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories
and Roerig Divisions of Pfizer Pharmaceuticals)

1:00 p.m. to 4:30 p.m.

Thursday, April 30

"Emotional Problems in Primary Care" — Joseph Talley, M.D., Clinical Assistant Professor, Department of Family Practice, University of North Carolina School of Medicine, Durham, N.C.

"Treatment of the Ambulatory Asthmatic" — Donald C. McLean, M.D., Clinical Assistant Professor of Pediatrics, Emory University Medical School, Atlanta, Georgia.

"Artery Spasm and Ischemic Heart Disease: The Role of Calcium Blockade" — Film with Accompanying Monograph

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of
Chest Physicians, and Florida Thoracic Society)

1:00 p.m. to 5:00 p.m.

Thursday, April 30

James W. Wynne, M.D., Gainesville

Program Chairman

"New Diagnostic Techniques in Chest Medicine"

"Two-dimensional Echocardiography" — Walter Henry, M.D., Professor of Medicine and Chief, Division of Cardiology, University of California, Irvine, California.

"CAT Scanning of the Chest" — Lawrence R. Muroff, M.D., Director of Nuclear Medicine and Computer Tomography, University Community Hospital, and Clinical Associate Professor of Radiology, University of South Florida College of Medicine, Tampa.

"Nuclear Medicine Techniques for Assessment of Right and Left Ventricular Performance" — Stuart Gottlieb, M.D., Clinical Associate Professor of Radiology, University of Miami School of Medicine, Miami.

"The Use of Pleuroscopy in the Diagnosis of Pleural Disease" — Jose F. Landa, M.D., Assistant Professor of Medicine, University of Miami School of Medicine, Miami.

SECTION ON ORTHOPEDIC SURGERY (SECTION I)

(Co-sponsored by Florida Orthopedic Society and
Professional Insurance Management Company)

1:30 p.m. to 4:45 p.m.

Thursday, April 30

George J. Fipp, M.D., Jacksonville

James W. Walker, M.D., Jacksonville

Program Co-Chairmen

"Medical Malpractice Prevention for the Orthopedic Surgeon"

In addition to being approved for AMA Category I Continuing Medical Education Credit on an hour-for-hour basis, this seminar will also satisfy the requirement that each physician insured by the Florida Physicians' Insurance Reciprocal attend a malpractice prevention seminar during 1981.

"Outline of Claims and Loss Experience" — Representative of Florida Physicians' Insurance Reciprocal Board of Directors.

"Causes and Prevention of Malpractice Claims (General)" — Legal Department, Professional Insurance Management Company, Jacksonville.

"Causes and Prevention of Orthopedic Malpractice Claims" — Claims Department, Professional Insurance Management Company, Jacksonville.

"First Notice of a Claim" — Claims Department, Professional Insurance Management Company, Jacksonville.

"How to Conduct Yourself in a Claim or Suit" — Legal Department, Professional Insurance Management Company, Jacksonville.

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Society of Rheumatology)

1:30 p.m. to 4:30 p.m.

Thursday, April 30

Robert Thoburn, M.D., Gainesville

Program Chairman

"Role of Histo-Compatibility Markers in the Study and Diagnosis of Rheumatic Diseases" — Claude Bennett, M.D., Professor and Chairman of the Department of Microbiology, and Director of the Division of Immunology and Rheumatology, University of Alabama School of Medicine, Birmingham, Alabama.

"Clinical Significance of Rheumatoid Factors" — Claude Bennett, M.D., Birmingham, Alabama.

"Vasculitis Syndromes" — Paul Katz, M.D., Assistant Professor of Medicine, Division of Rheumatology, University of Florida College of Medicine, Gainesville.

"Low Back and Leg Pain: Modern Concepts in Therapy" — Joseph Cauthen, M.D., Clinical Associate Professor of Neurological Surgery, University of Florida College of Medicine, and Private Practice, Gainesville.

SECTION ON BASIC LIFE SUPPORT CERTIFICATION

(Co-sponsored by FMA Committee on Continuing Medical Education and Broward Heart Association)

1:30 p.m. to 5:30 p.m.

Thursday, April 30

Karen R. Craparo, M.D., Hollywood

Program Chairman

Basic Life support is an emergency first aid procedure that consists of the recognition of respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life until a victim recovers sufficiently to be transported or until advanced life support is available.

A registrant who successfully completes this session will receive certification in basic life support from the American Heart Association.

This course is practical in nature and registrants should be prepared to participate actively. A demonstration of practical skills is a prerequisite for successful course completion and certification.

This year, the BLSC curriculum will be divided into two tracks:

1. *Recertification training for certified physicians* will last only two hours (1:30 p.m. to 3:30 p.m.) Only physicians presently certified by the American Heart Association and seeking renewal of certification will be admitted to this track. Limit: 60 participants.

2. Training for physicians not previously certified in CPR, spouses and convention guests will extend for four hours (1:30 p.m. to 5:30 p.m.) Limit: 60 participants.

NOTE: Advance registration for both tracks was conducted in March and April. Any openings in either track will be filled at course time at the door on a first come, first served basis.

SECTION ON FAMILY PRACTICE

(Co-sponsored by Florida Academy of Family Physicians)

2:00 p.m. to 5:00 p.m.

Thursday, April 30

Bernard Breiter, M.D., Daytona Beach

Program Chairman

"Saving Your Life" — Joseph B. Trainer, M.D., Clinical Professor of Preventive Medicine and Public Health, University of Oregon Health Science Center, Portland, Oregon.

"The Family Doctor and the Hospice — Experience of Nine Months of Florida's First Comprehensive Hospice" — Clyde M. Collins, M.D., Medical Director, Hospice of Methodist Hospital, Jacksonville.

"Animal Transmitted Diseases" — Oscar Sussman, D.V.M., Associate Epidemiologist/Veterinarian, Florida Health Program Office, Tallahassee.

FRIDAY MORNING, MAY 1

SECTION ON NUCLEAR MEDICINE

(Co-sponsored by Florida Association of Nuclear Physicians)

8:00 a.m. to 10:45 a.m.

Friday, May 1

Mukbil Hourani, M.D., Miami

Program Chairman

"RIA Evaluation of Hepato Biliary Dysfunction" — Fuad Ashkar, M.D., Miami.

"Hepato Biliary Imaging" — Mukbil Hourani, M.D., Assistant Professor, Nuclear Medicine, Jackson Memorial Hospital, Miami.

"CEA Radio Immuno Assay" — (Speaker to be Announced)

"GI Tract Imaging" — George Sfakianakis, M.D., Associate Professor of Radiology, Division of Nuclear Medicine, University of Miami School of Medicine, Miami.

SECTION OF CHEMICAL DEPENDENCY

(Co-sponsored by Florida Medical Foundation Committee on Impaired Physicians)

8:00 a.m. to 10:45 a.m.

Friday, May 1

Dolores A. Morgan, M.D., Miami

Program Chairman

Welcome — Guy T. Selander, M.D., Chairman, Florida Medical Foundation Committee on Impaired Physicians, Jacksonville.

"Identification and Motivation of the Chemically Dependent Physician" — G. Douglas Talbott, M.D., Program Director, Georgia's Disabled Doctors Program, Smyrna, Georgia.

"The Addict and Alcoholic of the 1980s" — Dolores A. Morgan, M.D., Medical Director, Florida Medical Association/Foundation Impaired Physician Program, Miami.

"Prescription Drug Abuse with Review of Education and Treatment Alternatives" — David Smith, M.D., San Francisco, California.

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)

8:00 a.m. to 10:45 a.m.

Friday, May 1

Thomas R. Bates, M.D., Orlando

Program Chairman

"Corneal Complications Following Cataract and IOL Surgery"

and Their Management" — Peter Laibson, M.D., Wills Eye Hospital, Philadelphia, Pennsylvania.

"PERK Study and Interesting Comments on Radial Keratotomy"

— Peter Laibson, M.D.

"Keratitis Sicca and Current Management" — Peter Laibson, M.D.

"Current Management of Herpes" — Peter Laibson, M.D.

SEMINAR ON MEDICAL MALPRACTICE PREVENTION

(Co-sponsored by Professional Insurance Management Company)

8:00 a.m. to 10:45 a.m.

Friday, May 1

James W. Walker, M.D., Jacksonville

Program Chairman

In addition to being approved for AMA Category I Continuing Medical Education Credit on an hour-for-hour basis, this seminar will also satisfy the requirement that each physician insured by the Florida Physicians' Insurance Reciprocal attend a malpractice prevention seminar during 1981.

"Introduction to Florida Medical Malpractice Problem" — Representative of Florida Physicians' Insurance Reciprocal Board of Directors.

"What We as Physicians Do to Get Sued and the Prevention of Suits" — Robert S. Brittain, M.D., President, Medical Liability Consultants Program, Inc., Denver, Colorado.

"How Do You Win?" — Robert S. Brittain, M.D., Denver, Colorado.

"How to Make a Cheap Suit Expensive — Fighting too Long, Failure to Cooperate, etc." — Robert S. Brittain, M.D., Denver, Colorado.

SECTION ON GASTROENTEROLOGY

(Co-sponsored by Florida Gastroenterologic Society)

8:00 a.m. to 10:45 a.m.

Friday, May 1

Arvey I. Rogers, M.D., Miami

Program Chairman

"Emotions and the GI Tract"

"Gastrointestinal Manifestations of Emotional Illness" — Pedro Greer, M.D., Clinical Associate Professor of Medicine, University of Miami School of Medicine, Miami.

"Globus Hystericus: Some Insights" — Philip Grossman, M.D., Clinical Instructor in Medicine, University of Miami School of Medicine, **"Irritable Bowel Syndrome"** (Panel)

Moderator:

Chester Cassel, M.D., Clinical Professor of Medicine, University of Miami School of Medicine, Miami.

Panelists:

Pedro Greer, M.D., Miami

Carlos Stincer, M.D., Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami.

"Emotional Manifestations of GI Disorders" — Arvey I. Rogers, M.D., Professor of Medicine, University of Miami School of Medicine, Miami.

"Psychogenic Vomiting" — Carlos Stincer, M.D., Miami.

"Peptic Ulcer Disease" (Panel)

Moderator:

Harris D. Shifrin, M.D., Clinical Assistant Professor of Medicine, University of Miami School of Medicine, Hollywood.

Panelists:

Arvey I. Rogers, M.D., Miami

Carlos Stincer, M.D., Miami

SECTION ON ORTHOPEDIC SURGERY (SECTION II)

(Co-sponsored by Florida Orthopedic Society)

8:30 a.m. to 10:45 a.m.

Friday, May 1

George J. Fipp, M.D., Jacksonville

Program Chairman

"Intraarticular Distal Humeral Fractures — Open Reduction" — John Jennings, M.D., Miami.

"Orthopedic Aspects of Common Dystrophies" — Michael G. Gurvey, M.D., Miami.

"Treatment of Dural Tears Associated with Spine Surgery" — Frank Eismont, M.D., Miami.

"What's Going on Out There?" — Michael Alms, M.D., Santo Domingo, Dominican Republic.

DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories and the Roerig Divisions of Pfizer Pharmaceuticals)

8:30 a.m. to 10:45 a.m.

Friday, May 1

"Hypertension — Emotional and Stress Factors" — J. Caulie Gunnells Jr., M.D., Professor of Medicine, Division of Nephrology, Duke University School of Medicine, Durham, North Carolina.

"Stress and the Diabetic" — Charles R. Shuman, M.D., Professor and Chief of the Metabolic Service, Temple University Hospital, Philadelphia, Pennsylvania.

SECTION ON EMERGENCY MEDICINE

(Co-sponsored by Florida Chapter, American

College of Emergency Physicians)

8:30 a.m. to 10:45 a.m.

Friday, May 1

Arthur Anderson, M.D., Fort Lauderdale

Program Chairman

"Coral Injuries" — Donald DeSylva, Ph.D., Professor of Marine Biology, Rosensteel School of Science, University of Miami, Miami.

"Shark Attacks" — Samuel Gruber, Ph.D., RSMAS/BLR, University of Miami, Miami.

"Animal Bites in Children" — Donald Weiffenbach, M.D., Lake City.

FRIDAY AFTERNOON, MAY 1

SECTION ON ENDOCRINOLOGY AND GASTROENTEROLOGY

(Co-sponsored by Florida Endocrine Society and Florida Gastroenterologic Society)

2:00 p.m. to 5:15 p.m.

Friday, May 1

Paul S. Jellinger, M.D., Hollywood

Stephen B. Novak, M.D., Hollywood

Arvey I. Rogers, M.D., Miami

Program Co-Chairmen

"GI Hormones: An Overview" — Sami Said, M.D., Department of Internal Medicine and Pharmacology, University of Texas South-

western Medical School, Dallas, Texas.

"GI-Endocrine Clinical Vignettes: Hyperglycemia, Hypoglycemia, Diarrhea and Wheezing" (Panel)

Moderator:

Paul S. Jellinger, M.D., Hollywood

Panelists:

Stephen B. Novak, M.D., Hollywood

Arvey I. Rogers, M.D., Miami

Sami Said, M.D., Dallas, Texas

"VIP: Current Concepts" — Sami Said, M.D., Dallas, Texas.

"GI and Endocrine Considerations in Peptic Ulcer Disease" (Panel)

Moderator:

Arvey I. Rogers, M.D., Miami

Panelists:

Lawrence M. Fishman, M.D., Miami

Jeffrey B. Raskin, M.D., Miami

Sami Said, M.D., Dallas, Texas

**SECTION ON RADIOLOGY
(SECTION I)**

(Co-sponsored by Florida Radiological Society)

2:00 p.m. to 6:00 p.m.

Friday, May 1

W. Thomas Hawkins, M.D., Gainesville

Program Chairman

Welcome — Donald R. Hansard, M.D., President, Florida Radiological Society, Tallahassee.

Introduction of Speakers — W. Thomas Hawkins, M.D., Program Chairman, Gainesville.

"Angiographic/CT Correlation in the Suprasella Region" — Ronald G. Quisling, M.D., Assistant Professor of Radiology, University of Florida College of Medicine, Gainesville.

"Contrast Cisternography" — Preston Lotz, M.D., Veterans Administration Hospital, Gainesville.

"Overview of Myelography" — Preston Lotz, M.D., Veterans Administration Hospital, Gainesville.

"Interventional Neuroradiologic Techniques" — Ronald G. Quisling, M.D., Assistant Professor of Radiology, University of Florida College of Medicine.

SECTION ON PEDIATRICS

(Co-sponsored by Florida Pediatric Society)

2:00 p.m. to 5:00 p.m.

Friday, May 1

Robert H. Threlkel, M.D., Jacksonville

Program Chairman

"The Management of Prolonged Sleep Apnea" — Dorothy H. Kelly, M.D., Department of Pediatrics, Harvard Medical School, Boston, Massachusetts.

"The Relationship Between Apnea and the Sudden Infant Death Syndrome" — Frederick Mandell, M.D., Department of Pediatrics, Harvard Medical School, Boston, Massachusetts.

SECTION ON PSYCHIATRY

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)

2:00 p.m. to 6:00 p.m.

Friday, May 1

Leslie L. Mate, M.D., Miami

Program Chairman

"The Differential Diagnosis of Dementia" — Jack Skigen, M.D., Clinical Professor of Psychiatry, University of Miami School of Medicine, Miami.

"Hyperactivity in Children and the Rest of Us" — Michael C. Hughes, M.D., Clinical Associate Professor of Psychiatry, University of Miami School of Medicine, Miami.

"The Psychotic Patient in the Office" — Jorge I. Casariego, M.D., Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami.

"Sleep Disorders in Medical Practice" — Brian L. Weiss, M.D., Clinical Associate Professor of Psychiatry, University of Miami School of Medicine, and Chairman, Department of Psychiatry, Mount Sinai Medical Center, Miami Beach.

"Psychobiology of Depression" — Richard M. Steinbook, M.D., Associate Professor of Psychiatry and Director of Resident Training, University of Miami School of Medicine, Miami.

"Stress and the Expert Witness" — Sanford Jacobson, M.D., Clinical Associate Professor of Psychiatry, University of Miami School of Medicine, Miami.

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and

Rectal Surgeons)

2:00 p.m. to 6:00 p.m.

Friday, May 1

Shed Roberson, M.D., Daytona Beach

Program Chairman

"Experience with the Short Colonoscope in Clinical Practice" — H. Whitney Boggs, M.D., Shreveport, Louisiana.

"Clinical Gastroenterology for the Colo-Rectal Surgeon" — H. Worth Boyce, M.D., Tampa.

"Anorectal Problems" (Panel)

Moderator:

Shed Roberson, M.D., Daytona Beach

Panelists:

H. Whitney Boggs, M.D., Shreveport, Louisiana

Emmett Ferguson, M.D., Jacksonville

Matthew Larkin, M.D., Miami

Albert G. Biehl, M.D., Boca Raton

"Pre-op Irradiation for CA of Rectum" — Shed Roberson, M.D., Daytona Beach.

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for

Preventive Medicine)

2:00 p.m. to 5:30 p.m.

Friday, May 1

James T. Howell, M.D., Tallahassee

Program Chairman

"Overview of the Comprehensive Cancer Center" — C. Gordon Zubrod, M.D., Director, Comprehensive Cancer Center for the State of Florida, Miami.

"Control Activities of the Center" — Peter W. A. Mansell, M.D., Chief of Education and Training, Comprehensive Cancer Center for the State of Florida, Miami.

"Florida Cancer Data System" — Burton Siebert, Ph.D., Project Director, Division of Biostatistics, Comprehensive Cancer Center for the State of Florida, Miami.

"State of Florida's Public Health" — James T. Howell, M.D., State Health Officer and Staff Director, Health Program Office, Tallahassee.
"Update Infectious Diseases — State of Florida" — Robert A. Gunn, M.D., State Epidemiologist, Tallahassee.

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic and
Cardiovascular Surgeons)

2:00 p.m. to 4:00 p.m.

Friday, May 1

David S. Hubbell, M.D., St. Petersburg
Program Chairman

"Nonpenetrating Injuries of the Heart and Thoracic Vessels" — Peter Symbas, M.D., Atlanta, Georgia.

"Update: Management of Chest Wall Injuries" — DeWitt Daughtry, M.D., Editor, *Thoracic Trauma*, Miami.

"Update: The Medical Management of the Patient with Pulmonary Trauma" — Allan Goldman, M.D., Division of Pulmonary Medicine, University of South Florida College of Medicine, Tampa.

"Trauma of the Chest" (Panel)

Peter Symbas, M.D., Atlanta, Georgia

DeWitt Daughtry, M.D., Miami

Allan Goldman, M.D., Tampa

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)

2:00 p.m. to 5:00 p.m.

Friday, May 1

Isaac Cohen, M.D., Miami Beach
Program Chairman

"Art and Science" — John B. Miale, M.D., Professor of Pathology, University of Miami School of Medicine, Miami.

Award Presentation

"Stress, Diet and Coronary Artery Disease" — William Roberts, M.D., National Heart, Lung and Blood Institute, National Institutes of Health, Bethesda, Maryland.

SECTION ON NEPHROLOGY

(Co-sponsored by Florida Society of Nephrology)

2:00 p.m. to 6:00 p.m.

Friday, May 1

Thomas C. Marbury, M.D., Gainesville
C. Craig Tisher, M.D., Gainesville
Program Co-Chairmen

"Current Topics in Nephrology"

"Diagnosis and Management of Diabetic Nephropathy" — C. Craig Tisher, M.D., Gainesville.

"Continuous Ambulatory Peritoneal Dialysis (CAPD) — A Revolutionary Approach in the Treatment of the Endstage Renal Disease Patient" — Donald Mars, M.D., Gainesville.

"Transluminal Angioplasty in the Treatment of Renovascular Hypertension" — James Mahoney, M.D., Gainesville.

"Hypertensive Disease of Pregnancy and the Renin-Angiotensin System" — Hugo R. Tapia, M.D., Lakeland.

SATURDAY MORNING, MAY 2

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic
and Reconstructive Surgeons)

8:00 a.m. to 12:45 p.m.

Saturday, May 2

M. Felix Freshwater, M.D., Miami
Program Chairman

Welcome — Jack D. Norman, M.D., President, Florida Society of Plastic and Reconstructive Surgeons, Miami.

"Abdominal Wall Reconstruction — New Techniques" — H. Hollis Caffee, M.D., Assistant Professor of Plastic and Reconstructive Surgery, University of Florida College of Medicine, Gainesville.

"Hand Revascularization — Case Report" — Nalin T. Master, M.D., Resident in Plastic and Reconstructive Surgery, University of Florida College of Medicine, Gainesville.

To Be Announced — Peter Chatard, M.D., First Year Fellow in Plastic and Reconstructive Surgery, University of Florida College of Medicine, Gainesville.

"Quadriceps Mechanism Muscle Flaps for Difficult Wound Coverage Problems" — Daniel I. Gruver, M.D., and M. Felix Freshwater, M.D., University of Miami School of Medicine, Miami.

"Modern Management of Pressure Sores with Myodermal and Muscle Flaps" — John E. Nees, M.D., and M. Felix Freshwater, M.D., University of Miami School of Medicine, Miami.

"New Techniques of Orbital Plastic Surgery" — S. Anthony Wolfe, M.D., University of Miami School of Medicine, Miami.

"Central Mound Technique for Reduction Mammoplasty" — Clyde R. Balch, M.D., Naples.

"The Soft Breast" (Film) — Lawrence B. Robbins, M.D., University of Miami School of Medicine, Miami.

"Current Problems in Plastic and Reconstructive Surgery of the Breast" (Panel)

Moderator:

Edward Truppman, M.D., North Miami Beach

Panelists:

Clyde R. Balch, M.D., Naples

Lawrence B. Robbins, M.D., Miami

Walter R. Mullin, M.D., Miami

SECTION ON OCCUPATIONAL MEDICINE

(Co-sponsored by Florida Occupational
Medical Association)

8:00 a.m. to 11:00 a.m.

Saturday, May 2

Joseph A. Baird, M.D., Belleair Beach
Program Chairman

"Current Topics in Occupational Health"

Welcome — Francis L. Bergquist, M.D., President, Florida Occupational Medical Association, Lakeland.

"Occupational Health Education in Florida Universities" — Nicholas Alexiou, M.D., Director, Division of Occupational Health, University of South Florida College of Medicine, Tampa.

"Alcoholism in Industry" — Vann A. Brewster, M.D., Director of Health Services, Florida Power Corporation, St. Petersburg.

"Life, Stress, and the Lower Back" — Maurie D. Pressman, M.D., Medical Director, Horizon Hospital, Clearwater, Florida, and Clinical Professor of Psychiatry, Temple University School of Medicine, Philadelphia, Pennsylvania.

"Standards Completion Program, OSHA and NIOSH" — Loren L. Hatch, D.O., Ph.D., University of South Florida College of Medicine, Tampa.

SECTION ON ORTHOPEDIC SURGERY (SECTION III)

(Co-sponsored by Florida Orthopedic Society)

8:00 a.m. to 10:45 a.m.

Saturday, May 2

George J. Fipp, M.D., Jacksonville

Program Chairman

"Concepts in Management of Severe Open Tibial Fractures Utilizing External Fixation and Cast Brace" — John Nordt, M.D., Miami.

"Operative Treatment of Thoracic-Lumbar Fractures" — Richard Ganzhorn, M.D., Russell Clark, M.D., and Howard Hogshead, M.D., Jacksonville.

"Running Injuries" — Russell Clark, M.D., Jacksonville.

"What Should We Teach Them?" — Michael Alms, M.D., Santo Domingo, Dominican Republic.

SECTION ON SURGERY

(Co-sponsored by Florida Chapter,
American College of Surgeons)

8:00 a.m. to 12:00 noon

Saturday, May 2

Arthur K. Waltzer, M.D., Tampa

Program Chairman

"Multidisciplined Approach to Trauma — Changing Concepts"

"Recent Advances in Neurosurgery" — Gene A. Balis, M.D., Assistant Professor of Surgery and Director, Division of Neurosurgery, University of South Florida College of Medicine, Tampa.

"Recent Advances in the Management of Facial Injuries" — Joel Mattison, M.D., Clinical Professor of Surgery, University of South Florida College of Medicine, Tampa.

"Pulmonary Complications in the Traumatized Patient" — Allan Goldman, M.D., Associate Professor of Medicine, Division of Pulmonary Disease, University of South Florida College of Medicine, Tampa.

"Resuscitation and Current Concepts in the Diagnosis of Abdominal Trauma" — Arthur K. Waltzer, M.D., Assistant Professor of Surgery, University of South Florida College of Medicine, Tampa.

"Management of Orthopedic Injuries" — Phillip G. Spiegel, M.D., Professor of Surgery and Director, Division of Orthopedics, University of South Florida College of Medicine, Tampa.

"Management of Injuries to the Urinary Tract" — Steven Woodrow, M.D., Assistant Clinical Professor of Urology, University of South Florida College of Medicine, Tampa.

SECTION ON ALLERGY

(Co-sponsored by Florida Allergy Society)

8:30 a.m. to 12:00 noon

Saturday, May 2

Richard F. Lockey, M.D., Tampa

Program Chairman

Welcome — Richard F. Lockey, M.D., Program Chairman, Tampa

"Pharmacokinetics of Theophylline" — Saber Samaan, M.Sc.,

Division of Allergy and Immunology, University of South Florida College of Medicine, Tampa.

"The Use of the Radioallergosorbent Test (RAST) in Clinical Practice" — Robert E. Reisman, M.D., Clinical Professor of Medicine and Pediatrics, Division of Allergy and Immunology, University of New York at Buffalo, Buffalo, New York.

"Membrane Receptor Immunology — Clinical Implications" — Samuel C. Bukantz, M.D., Professor of Medicine and Director, Division of Allergy and Immunology, University of South Florida College of Medicine and Veterans Administration Hospital, Tampa.

"Hypersensitivity Diseases of the Lung" — Robert E. Reisman, M.D., Buffalo, New York.

SECTION ON UROLOGY

(Co-sponsored by Florida Urological Society)

8:30 a.m. to 11:30 a.m.

Saturday, May 2

Marvin J. Bondhus, M.D., Miami

Program Chairman

"Seminar on Urinary Tract Lithiasis" — Marvin J. Bondhus, M.D., Department of Urology, Jackson Memorial Hospital, Miami, Moderator.

Milton P. Coplan Pyelogram Hour — Richard B. Moore, M.D., West Palm Beach, Chairman.

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)

8:30 a.m. to 12:00 noon

Saturday, May 2

Taylor H. Kirby Jr., M.D., Gainesville

Program Chairman

The Obstetrical and Gynecological Program will be presented by the three departments of OB-GYN of the medical schools in Florida: University of Florida, Gainesville; University of South Florida, Tampa; and University of Miami, Miami.

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)

9:00 a.m. to 12:00 noon

Saturday, May 2

Phillip Frost, M.D., Miami Beach

Program Chairman

"Contact Urticaria" — E. K. Edwards Jr., M.D., Department of Dermatology, Mount Sinai Medical Center, Miami Beach.

The Annual Norman Fogel Memorial Lecture: "Perfume Reactions" — Jere D. Guin, M.D., Clinical Assistant Professor of Dermatology, Indiana University School of Medicine, Kokomo, Indiana.

"Migration of Topical Medications from the Site of Application" — Richard A. Johnson, M.D., Department of Dermatology, Mount Sinai Medical Center, Miami Beach.

"Effect of UVB on Sensitization to Nitrogen Mustard During Psoriasis Therapy" — Bernard P. Nusbaum, M.D., Department of Dermatology, Mount Sinai Medical Center, Miami Beach.

"Long Term Follow-up of Mycophenolic Acid For Use in the Treatment of Psoriasis" — Eliot C. Zweig, M.D., Department of Dermatology, Mount Sinai Medical Center, Miami Beach.

The Annual Wiley Sams Lecture: "Clinical Advances in Spotting Diseases of the Skin" — Sidney Klaus, M.D., Professor of Dermatology, Yale University School of Medicine, New Haven, Connecticut.

SECTION ON NEUROLOGY AND NEUROSURGERY

(Co-sponsored by Florida Society of Neurology and
Florida Neurosurgical Society)

9:00 a.m. to 12:00 noon

Saturday, May 2

B. L. Bercaw, M.D., Clearwater

Gaston J. Acosta-Rua, M.D., Jacksonville

Program Co-Chairmen

"Pituitary Surgery on Disorders of the Pituitary Gland" — Albert L. Rhoton Jr., M.D., Professor and Chairman, Department of Neurological Surgery, University of Florida College of Medicine, Gainesville

"Amenorrhea, Galactorrhea and Prolactin Secreting Tumors" — Frank C. Rigall, M.D., Assistant Professor of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville.

"Neuroradiologic Aspects of Pituitary Tumors" — O. Frank Agee, M.D., Professor of Radiology, University of Florida College of Medicine, Gainesville.

"Endocrinologic Aspects of Pituitary Tumors" — Peter W. Stacpoole, M.D., Department of Medicine, University of Florida College of Medicine, Gainesville.

1. University of Florida College of Medicine
 2. University of South Florida College of Medicine
 3. University of Miami School of Medicine
 4. Mount Sinai Medical Center of Greater Miami
-

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

(Co-sponsored by Florida Society of
Physical Medicine and Rehabilitation)

10:00 a.m. to 12:00 noon

Saturday, May 2

Solomon Winokur, M.D., Lake Worth

Program Chairman

"Newer Developments in Electromyography" — Ernest Johnson, M.D., Professor and Chairman, Department of Physical Medicine, Ohio State University College of Medicine, Columbus, Ohio.

SECTION ON RADIOLOGY (SECTION II)

(Co-sponsored by Florida Society of Radiology)

9:00 a.m. to 11:00 a.m.

Saturday, May 2

W. Thomas Hawkins, M.D., Gainesville

Program Chairman

Introduction of Speakers — W. Thomas Hawkins, M.D., Program Chairman, Gainesville.

"Digital Subtraction Radiology" — (Speaker to be Announced)
Resident Papers

SATURDAY AFTERNOON, MAY 2

SECTION OF INTERNATIONAL COLLEGE OF SURGEONS

(Co-sponsored by Florida State Surgical Division,
International College of Surgeons)

1:30 p.m. to 2:30 p.m.

Saturday, May 2

Robert H. Hux, M.D., Leesburg

Program Chairman

"Acute Arterial Occlusion: Diagnosis and Management" — Andrew Sharf, M.D., Past President, United States Section, International College of Surgeons, Glendale, California.

Restaurants of the Gold Coast

Charles A. Monnin Jr., M.D.

Editor's Note: "Where's a good place to eat?" will be a frequently asked question when physicians convene for the 107th Annual Meeting of the Florida Medical Association in Hollywood late this month. Dr. Charles A. Monnin Jr., of Hialeah, is a man with the answers. Dr. Monnin is a connoisseur par excellence, with such distinguished credentials as: Chevalier Ordre Du Merite Agricole, French; Commandarie De Bordeaux, France; Bailli of Miami Chapter of Confrerie de la Chaine des Rottisseurs; Judge in Budapest of Culinaire Arts with Chaine des Rotisseurs, 1968; Member, International Wine and Food Society; and Member, Miami Chapter, Sommelier Guild.

Professionally, Dr. Monnin is a Clinical Assistant Professor of Surgery at the University of Miami School of Medicine, a Diplomat of the American Board of Surgery, and a Fellow of the American College of Surgeons. *The Journal* asked Dr. Monnin to prepare a restaurant guide for physicians attending the Annual Meeting. Here is his report.

The FMA convention at the Diplomat Hotel in Hollywood places us in the heart of some of the finest eateries and feederies in America — certainly better than one would find in Chicago, Los Angeles and many of the other great cities, in my opinion. Coral Gables and South Miami have been blessed with an excellent concentration of fine restaurants, but they are not listed here because of the distance.

I also will not mention Joe's Stone Crab Restaurant at the extreme end of Miami Beach. However, stone crabs are available in most of the better restaurants. Listed below are but a few of the hundreds of restaurants on our Gold Coast. An indication of price is provided, but this can vary depending on the "extras" being ordered. *Reservations are suggested for all.*

The first three restaurants listed are owned and operated by the Picot family and have received almost all

of the culinary awards possible.

Casa Vecchia
209 North Birch Road
Fort Lauderdale
463-7575

Excellent Italian. Overlooks the intracoastal waterway. Expensive.

La Vieille Maison
770 East Palmetto Park Road
Boca Raton
391-6701

A little drive, all expressway. Well worth it! Superb food. Antique "Old House" decor. Open daily. Expensive.

The Down Under
3000 East Oakland Park Boulevard
Fort Lauderdale
563-4123

Very popular. Very good. American and European dishes. Moderately expensive.

Les Trois Mousquetaires
2447 East Sunrise Boulevard
Fort Lauderdale
564-7513

An intimate restaurant with French haute cuisine. Expensive.

The French Quarter
Cafe de Paris
Las Olas and Southeast 8th Avenue
Fort Lauderdale
463-8000 467-2099

Both open for lunch, dinner, supper. Dancing upstairs. The owner, Louis Flemati, a Swiss, is always on the scene,

having developed these two magnificently landscaped restorations with their French, New Orleans menu. They are among the most distinctive restaurants in Fort Lauderdale. Expensive.

Il Giardino's

609 East Las Olas Boulevard
Fort Lauderdale
763-3733

Well prepared Italian dishes with paddle fans overhead, thriving greenery with a soft, quiet mood.

Mai-Kai

3599 North Federal Highway
Fort Lauderdale
563-3272

One of the nations top purveyors of Polynesian-type foods — the type that made Trader Vic's famous. Nightly review of beautiful sarong-clad girls and knife-throwing strong men. Moderate.

Portage

1717 Eisenhower Boulevard
(Just off 17th Street Causeway)
Fort Lauderdale
467-6600

Continental restaurant, exquisite cuisine and quiet elegance. Overseen by Peter Scheuerl.

Pier 66

2301 Southeast 17th Street Causeway
Fort Lauderdale
524-0566

A sky-scraping pause with a view of one of the world's great marinas. The elevator takes 66 seconds; the floor rotates every 66 minutes. An excellent place to begin an evening of dining. No food. Great for cocktails.

La Ferme

1601 East Sunrise Boulevard
Fort Lauderdale
764-0987

Well patronized by many of our local colleagues. Moderate.

Wine Celler

2651 North Federal Highway
Fort Lauderdale
565-9021

Austrian-German cuisine. Very small. Very good. Moderate.

Yesterdays

3001 East Oakland Park Boulevard
Fort Lauderdale
561-4400

Lovely atmosphere. Good Food. Moderately expensive. The Plum Room on top is interesting. Expensive.

Forge Restaurant

432 Arthur Godfrey Road
Miami Beach
538-8533

Open until 2 a.m. Decorated with art treasures. Large wine cellar. Very good. Expensive.

Cafe Chaveron

9561 East Bay Harbor Drive
Bay Harbor
866-8779

Holiday Award for fine dining. Expensive.

**Post and Paddock Restaurant,
L'Hostellerie d'Argenteuil**

9650 East Bay Harbor Drive
Miami Beach
866-8706

Very popular locally. Horsey decor. Lunch and dinner. Expensive.

Ristorante Tiberio

9700 Collins Avenue
Bal Harbour
861-6161

In the Bal Harbour Shops. Excellent and expensive.

Tark's (3 locations)

1317 South Federal Highway, Dania Tel. 925-TARK
Route 441 and Peters Road, Plantation, Tel. 792-TARK
4300 Hollywood Boulevard, Hollywood, Tel. 962-CLAM

Raw Bar. Very modest, bar type surroundings with tremendous turnover of clams, oysters, chicken wings, assuring excellent fresh quality. One of Dr. Joe Davis' (Past President) favorites. No coats and ties. Moderate.

Chuck's Steak House (2 locations)

1201 Southeast 17th Street Causeway, Fort Lauderdale, 527-4400
300 South State Road #7, Plantation, 584-8817.

No reservations. Known for its steaks and prime rib. Excellent salad bar. A real bargain. (About \$12.00) Moderate.

Umberto's
308 North Federal Highway
Hallandale
456-2110

Umberto's of Long Island, famous for its southern Italian style food — clams marinara — a side order of fettuccine to soak up the marinara sauce — that's real living! Famous for their pasta, fish courses and veal, not to mention their espresso. It is one of several family-owned operations between here and Long Island.

Marker #88
West Side of U.S. 1
At Mile Marker 88
South Tavernier (Florida Keys)
852-9315

Outstanding and worth the trip.

Many thanks to Yolanda Maurer, Editor and Publisher of *The Best of Broward*, for her assistance and advice.

FMA Annual Meeting Program to Schedule Basic Life Support Certification

The Committee on Continuing Medical Education is pleased to announce that basic life support certification training will be provided at the 107th Annual FMA meeting at Hollywood, Florida in April.

The Broward Heart Association is providing the training on Thursday afternoon, April 30, at the Diplomat Hotel. Karen R. Craparo, M.D., of Hollywood, is course director.

This year, two different tracks will be available, including a two-hour curriculum for physicians seeking renewal of their American Heart Association Certification. This program will begin at 1:30 p.m. and conclude at 3:30 p.m.

The standard four-hour curriculum also will be available and will be open to physicians not previously certified, spouses of physicians and other individuals registered for the Annual Meeting.

Each track will have a maximum enrollment of 60, with advance registration requested. Any openings remaining after advance registration will be filled at the door on a first-come, first-served basis.

There is no registration fee. Course materials will be mailed to enrollees who register in advance.

Physicians attending the program may claim two or four hours of AMA Category I Credit, depending upon which program is selected.

The following form should be filled out and mailed to the Broward Heart Association, to arrive no later than April 15, 1981.

..... CUT ALONG THIS LINE

Advance Registration For CPR/BASIC LIFE SUPPORT TRAINING

I wish to enroll in (check appropriate block).

- ☐ Recertification training for certified physicians (1:30 p.m. to 3:30 p.m., Thursday, April 30). NOTE: Only physicians presently certified by the American Heart Association and seeking renewal of certification will be admitted to this track.
- ☐ Training for physicians not previously certified in CPR, spouses and convention guests. (1:30 p.m. to 5:30 p.m., Thursday, April 30).

PLEASE PRINT:

Name _____
LAST FIRST MIDDLE

Mailing Address _____
STREET or P.O. BOX CITY STATE ZIP

Mail by April 12, 1981: Broward Heart Association
P.O. Box 14213
440 N. Andrews Avenue
Ft. Lauderdale, Florida 33302

Return your registration form as soon as possible so that the course materials can be mailed to you for reading prior to the class date.

..... CUT ALONG THIS LINE

Alert and
functioning
in the
sunset
years

Treat the symptoms in
the geriatric patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule
contains:

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Scientific and Educational Exhibits Exhibit Hall 1981

- A "Treatment of Pigmy Rattlesnake Envenomation" — William J. Bailey, M.D., Naples
- B "Genital Herpes Infection in the Female" — Pierre J. Bouis Jr., M.D., Dept. of OB/GYN, University of South Florida College of Medicine, Tampa.
- C "Experience with One Hundred Consecutive 'Physiologic' Pacemakers (A-V Sequential and Atrial)" — Diego A. Bognolo, M.D., Tampa.
- D "South Florida Chapter of the Asthma and Allergy Foundation of America" — Mrs. Marie Traub, South Florida Chapter of the Asthma and Allergy Foundation of America, Hollywood.
- E "Disability Evaluation Under the Social Security Act" — G. M. Davis, M.D., HRS Office of Disability, Tallahassee.
- F "Everything You Wanted to Know About Public Health But Were Afraid to Ask" — Robert D. May, M.D., Pasco County Health Department, New Port Richey.
- G "A Community Cancer Center" — H. D. Kerman, M.D., and others, Cancer Committee, Halifax Hospital Medical Center, Daytona Beach.
- H "Computed Tomographic Anatomy of the Brainstem" — H. N. Schnitzlein, Ph.D., and others, University of South Florida College of Medicine, Tampa.
- J "International College of Surgeons" — Robert Hux, M.D., Regional Membership Chairman, Leesburg.
- K "Alcohol Use and Abuse Awareness Exhibit" — Barbara Lauer, Florida Citizens' Commission on Alcohol Abuse, Inc., Tallahassee.
- L-M "Surgical Treatment of Male Impotence" — John W. Devine Jr., M.D., and others, Dept. of Urology and Division of Plastic Surgery, University of Miami and VA Hospital, Miami.
- N-O "Gastrointestinal Radionuclide Studies in Pediatric Age" — G. N. Sfakianakis, M.D., Florida Association of Nuclear Physicians, Miami.
- P "Cardiac Arrest: The First Ten Minutes" — Ramon Rodriguez-Torres, M.D., Miami.
- Q "Monoclonal Antibodies — A Powerful Diagnostic and Therapeutic Tool" — Burton Feinerman, M.D., Miami.

- R "South Florida Emergency Medical Service Council" — Laurel Ullrich, South Florida Emergency Medical Service Council, Miami.
- S "The American Society for Parenteral and Enteral Nutrition" — Kristie Rode, Washington, D.C.
- T-U "Recent Advances in Treatment and Evaluation of Ear Disease" — Fredric W. Pullen II, M.D., and others, Miami Hearing and Speech Center, Miami.
- V "Coronary Arteriography After Bypass Surgery" — Paul F. Eckstein, M.D., and others, Tampa.
- W "Heparin Potentiates Platelet Aggregation" — Paulette Mehta, M.D., University of Florida College of Medicine, Gainesville.
- X, Y, Z,
AA, BB,
CC, DD
& EE Programmed Instruction/Wyeth AutoTutors®
- FF "Illustrations of the American Spinal Cord Injury Association Nomenclature" — Barth A. Green, M.D., and others, South Florida Regional Spinal Cord Injury System, Miami.
- GG "Evaluation of 45 Asthmatic Children and Their Parents in an Educational and Exercise Program" — Michael Kohen, M.D., Daytona Beach.
- HH "Hospice in Florida" — Stella Monchick, Florida State Hospice Organization, Lake Worth.
- JJ-KK "The Scope of Plastic Surgery" — S. Anthony Wolfe, M.D., Florida Society of Plastic and Reconstructive Surgery, Miami.
- F-1 "Radial Keratotomy — A Surgical Cure for Myopia" — Jerry Zelman, M.D., Hialeah.
- F-2 "Living with an Ostomy" — Broward Ostomy Association, Mr. Bert Kronheimer, Hallandale.
- F-3 "Sudden Infant Death Syndrome" — Dr. Betty McEntire, Florida Department of Health and Rehabilitative Services, Tallahassee.

*We love the same country.
We care about the same things.
We dream the same dreams.
1981. The International Year
Of Disabled Persons.*

*President's Committee on
Employment of the Handicapped
Washington, D.C. 20210
The School of Visual Arts
Public Advertising System*

A peripheral vasodilator

for treatment of
**leg cramps
cold feet
tinnitus
discomfort on
standing**

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



ENERGY IS EVERYTHING.

SAVE IT AT HOME

You can save a bundle of money right in your own home.

When you waste energy at home, you not only hurt your state and your country, you also hurt yourself and your family. Because you're literally burning up money that could be used for a lot of other worthwhile purposes.

Here are six easy ways for you to save energy at home.

1. Have a home energy audit to discover how you may save thousands of dollars on energy costs in the 80's. Call your local power company.
2. Keep your cooling-heating thermostat set no lower than 78° in summer, no higher than 65° in winter.
3. Keep your water heater set no higher than 120° (140° if you use a dishwasher). Wrap it with an insulating blanket. And turn it off when you're away for weekends.
4. Keep outside air out by caulking and weather stripping doors and windows.
5. Increase the amount of insulation where you live. Use window shades, trees and awnings to encourage natural cooling.
6. Send for Florida's tips on how to save money and energy at home.

Write: Save it at home, The Capitol, Tallahassee, Florida 32301.

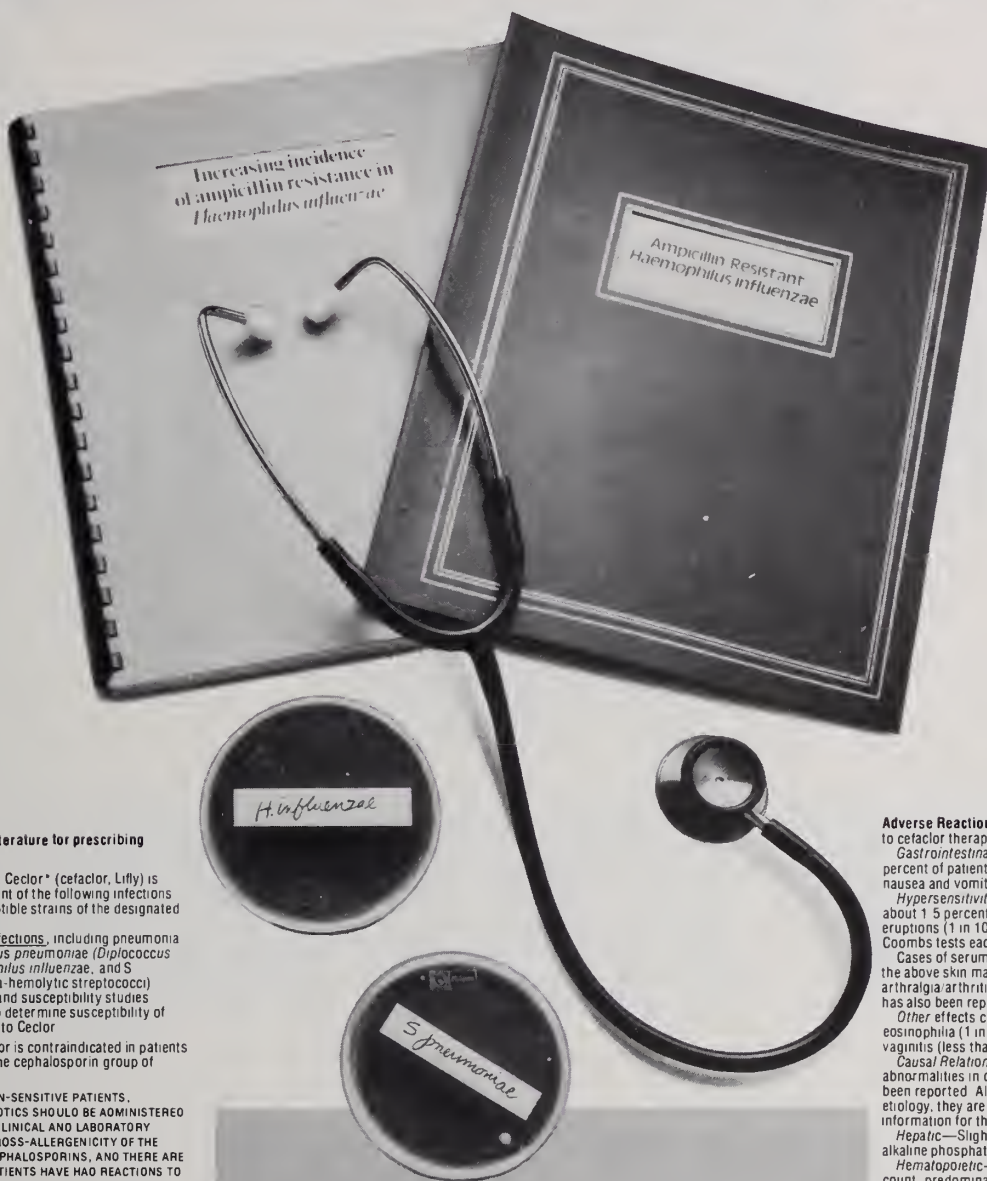
In today's world, energy is everything. Save it at home. Save it, Florida.



SAVE IT, FLORIDA.

This message brought to you by The Governor's Energy Partner.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor* (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS. CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [1030808]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor* (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
3. Antimicrob. Agents Chemother., 13: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), 11: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

100061

We're not asking you for money.

Just a few words. To people who need us but don't know we exist.

We're Recording for the Blind. We're already helping more than 13,000 handicapped students. But there are a lot more out there who need our help.

You know who they are. In your work you come across students who are blind, dyslexic or physically unable to handle books. These are the students we help. Since they cannot read their textbooks, we do it for them. On tape. And we send the tapes to the students free of charge.

All we want you to do is tell eligible students about us. Have them contact: Student Services, RFB, Inc., 215 East 58th Street, N.Y., N.Y. 10022, (212) 751-0860. We'll take it from there.

It's such a little thing to ask.

Recording for the Blind is a non-profit organization. All contributions are tax-deductible.

Recording for the Blind, Inc.

an educational lifeline.



FMA AUXILIARY

Citrus, Seafood Sales Aid Impaired Physicians

The Florida Medical Association Auxiliary raises money for the Florida Medical Foundation by selling citrus and seafood. Thirty percent of your order for citrus and seafood is a tax deductible contribution to FMF. Last year the profits were increased four times over previous years. Our profit of \$2,083. was given to FMF for the Impaired Physicians Fund. Our goal this year is to double that amount. It looks as though we will exceed our goal, thanks to all of you for your large orders.

This success has been achieved with the help of our supplier, one of the largest gift fruit shippers in Florida.

Choice citrus is obtained from throughout the state. The fruit is washed, polished, waxed and packed in special cartons to protect it in shipment. It is available from mid-November until the end of June, except for an industry-wide embargo for 7 to 10 days over Christmas each year. When there is a hard freeze, shipments are halted until quality can be assured.

Gourmet seafoods are selected from the best catches from around the peninsula of Florida. They are prepared, quick frozen and shipped, packed in dry ice, in especially designed styrofoam containers. The packaging techniques preserve the seafood for 10 days or more. This excellent seafood is available the year around.

Our supplier ships citrus and seafood on his own trucks to major cities and from there individual deliveries are made by Parcel Post or United Parcel Service. This system assures rapid delivery and provides maximum protection for your gift en route. Replacement is made in the rare event of problems.

What a great idea to share wholesome food with family and friends!

Special free wrappings are available for these occasions:

Thanksgiving	Mother's Day
Holiday Greetings	Birthday
Star of David	Anniversary
Season's Greetings	Thank You

Valentine's Day
Easter

Congratulations
Get Well Soon

Three-month and six-month plans are ideal for senior citizens in rest homes, students living away from home and others residing alone.

Can you think of anything better than a gift of Florida Sunshine! What better gift can a physician's family give?

This program resulted from an idea conceived by the late Dr. William Feirer. While he was shopping in a department store in one of our large cities he noted someone placing an order for gift fruit and learned that there is a substantial fee for taking this order.

Last year was my first year as State Chairman of this project. As time went on I was amazed how much there was to learn and share about these tasty gifts. Our supplier has been most helpful and encouraging. It became almost a full time job for me. Fortunately our State President, Mrs. Fred Swing, realized the importance of this project and found a co-chairman, Mrs. David (Sande) Whitaker, to assist me this year. She has really been a life saver. I could not have survived without her. My telephone has been ringing morning, noon and night especially during November and December. Many trips were made to the Post Office to get information to the doctors in time for the holiday.

Florida Medical Association in Jacksonville has cooperated in every possible way. *The Journal of the Florida Medical Association* has run ads in every issue this 1980-81 year. The response has been tremendous. Thank you.

These have been two great and most exciting years with the full cooperation from supplier, physicians, and the FMA Office. Thank you each one for making this possible and at the same time helping our own physicians.

Mrs. C. Brooks (Ruth) Henderson
FMAA Chairman
Florida Medical Foundation

**When painful spasm
is the presenting
symptom...**

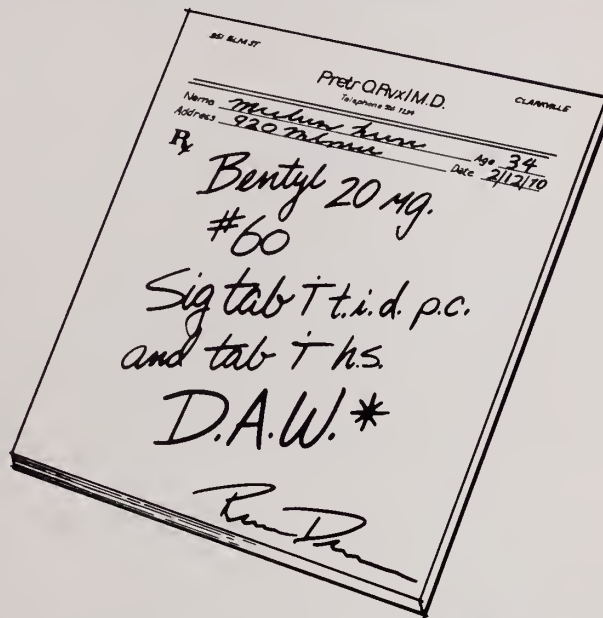


...in the functional bowel/irritable bowel syndrome[†]

be sure to specify

Bentyl[®]
(dicyclomine
hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injectable



**D.A.W.-Dispense as written*

because:

Bentyl passes these tests for product integrity.

- ⊕ The Bentyl molecule is a product of original Merrell research.
- ⊕ At Merrell, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable.
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablets, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Pharmacologic effect in the distal colon compared to placebo^{††} shows how Bentyl affects abnormal motor activity in the irritable colon patient.[†]

[†] This drug has been classified "probably" effective for this indication.

Merrell

^{††} In the experiments that showed significant pharmacologic effect, the dose of Bentyl used was 50 mg. I.M., which is higher than that permitted in the labeling. This dose was deemed justified since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level that occurs after a single 50 mg. I.M. dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective.

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness, drowsiness; weakness; dizziness; insomnia; nausea, vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSEAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup. *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACEUTICAL COMPANY
Ocaturo, Illinois 62525 for
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Merrell

0-6546 (Y115C) MNQ 442

The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment



CONVENTION PRESS, INC.

2111 NORTH LIBERTY ST.
JACKSONVILLE,
FLORIDA 32206

PHONE 904/354-5555



Correspondence

1981 LEGISLATIVE PROGRAM DEVELOPS

To the Editor: The Florida Medical Association Board of Governors and the Council on Legislation have spent countless hours in reviewing and analyzing legislative issues that will be considered by the 1981 Florida Legislature. We have received valuable input from specialty organizations, and have given priority attention to their important legislative concerns in our program objectives.

The FMA Auxiliary is once again being counted on to provide their valuable grass roots support that is so essential for success. A "LEGS Alert" system is established that will generate the letters and telegrams necessary to back up our lobbying program.

As the 1981 Program was developed, we determined to give priority attention in the early stages to several budget issues. The biennial budget process used by the Florida Legislature requires approval in 1981 else an issue will be deferred until the 1983 Session. Among the budgetary priorities established are:

- \$600,000 for full-time medical direction and long-range planning for the EMS system.
- \$10,900,000 in increased funding for county health units.
- \$30,500,000 for increases in physician reimbursement under Medicaid.
- \$1,800,000 for prenatal and postnatal care for the indigent.
- \$8,900,000 for increased salaries for state-employed physicians and nurses.
- \$5,200,000 increase for school health services.

None of these were recommended by the Governor for funding at the full amounts, and the increase for physician reimbursement under Medicaid was deleted entirely. This will make it much more difficult to develop legislative support for the increases sought.

A major thrust of the FMA's legislative program during 1981-82 will be directed toward problems created through encroachment from other health professionals. This includes the use of drugs by other than those specifically licensed to dispense and administer medicine and

the scope and practice of Advanced Registered Nurse Practitioners. The Association is actively working with several specialty organizations in putting together a package of proposed statutory and regulatory changes addressing these problems to be proposed during the 1981-1982 sessions. Special fact sheets with additional information on these subjects are being distributed to county societies and specialty groups.

Legislative Proposals Filed of Critical Concern

There are already several bills filed that have significant adverse impact on the health care consumer and the practice of medicine in Florida. Among the issues being actively opposed by the FMA are:

- Proposal to provide state subsidy to state employees who enroll in HMO's (Governor's Budget).
- Hospital privileges for chiropractors (HB 242).
- Establishment of chiropractic college in Florida (HB 268).
- Authorization for optometrists to use and prescribe drugs.
- Licensure of Homeopathic physicians (HB 49).
- State takeover of county health units (SB 162).
- Mandated use of problem-oriented medical records (SB 106).

With time left for the filing of bills, it is certain that other legislation of an adverse nature will be filed. If past patterns continue, there will be almost 400 bills filed that have some impact on medicine, with 40-50 of these being of a critical nature.

Professional Liability

The Professional Liability Insurance issue remains a great concern to the Florida Medical Association and its members. Notwithstanding the enactment of the Recovery of Costs statute in 1980, the entire situation remains volatile and must be monitored almost on a day-to-day basis to ensure that all aspects of the situation are addressed appropriately.

At this point in time, we are unable to accurately analyze the effects of the Recovery of Costs statute. Unfortunately, the statistics obtained from the Florida Physicians' Insurance Reciprocal, the FMA sponsored-insurance program, indicate that claims are continuing to increase rapidly in both severity and frequency. This, coupled with the drastic inflationary economy that has been visited upon us during the last five years, has brought the FMA sponsored PLI program to a point where it had to increase rates across the board twenty percent effective January 1, 1981.

We do not feel that the Recovery of Costs statute alone will resolve the serious problem that confronts patients and physicians alike in their efforts to resolve the malpractice dilemma. The Florida Medical Association is continuing to study other areas of the court system wherein it is believed that legislative adjustment might be necessary in order to again place the respective parties; e.g., patients who are potential plaintiffs and physicians, in a more equal bargaining position. Such areas as bad faith claims, punitive damages and the statute of limitations all need to be fully investigated, and possibly revised in order to prevent plaintiff's attorneys from taking cheap shots at medical practitioners.

While the challenges for the 1981 Legislature are significant, we look forward to another successful year. This is primarily because of the enthusiastic dedication of the county medical societies, and local auxiliaries in getting the contacts made at the local level. As has been said so many times, your Tallahassee-based efforts are only a conduit for the energies generated in the home communities of the individual legislators. The FMA is fortunate to have these resources available, and they will continue to be the priorities for our attention and efforts.

*Louis C. Murray, M.D., Chairman
Council on Legislation
Orlando*

1980 ACTIVE FOR FLAMPAC

To the Editor: The year 1980 was an extremely active one for the Florida Medical Political Action Committee. FLAMPAC contributed to 120 candidates for the legislative and congressional seats in the amount of \$140,083. While there were many factors contributing to these successes, the four most significant ones were:

1. Increased support given to FLAMPAC's Political Education Programs by the FMA, primarily through the activities of the three Field Office Directors.
2. The members of the FMA Auxiliary provided significant leadership at the local level in carrying out the

"people" responsibilities that were so essential to these successes.

- a. Registration drive and identification of precinct registration.
 - b. Conducting "Get Out The Vote" drives.
 - c. Securing the campaign volunteers that are basic to a winning campaign. This included voluntary service in the campaign offices, coffees and cocktail parties for candidates and participation in activities such as, precinct walks, etc.
3. The contributions by local physicians to candidates in their communities of:
 - Personal contributions
 - Serving on Finance Committees
 - Writing letters on behalf of candidates
 - Setting up and conducting hospital tours, etc.

All of which increased the physicians profile with the legislators.

4. FLAMPAC hired a full-time Field Activities Coordinator, who traveled the state assisting in candidate selection, auxiliary efforts, fundraising and donated time directly to target race campaigns.

While FLAMPAC contributed to a considerable number of races, at the beginning of the year, the Board determined that it would concentrate its efforts on a select number of target races. I am pleased that of the 15 target races, FLAMPAC was on the prevailing side of 14. Particularly important was the Board's willingness to determine at an early date to get involved in the campaigns of several newcomers.

FLAMPAC's membership during 1980 reached an all-time high of 4,443 members. It is particularly important to note the fact that our Sustaining Membership and Auxiliary Membership substantially exceeded the number in prior years.

1982 will be a particularly critical election year because of the redistricting process. The Florida legislature in 1982 will re-establish district boundaries for every congressional seat and the entire State Legislature. Florida has four new congressional seats which will increase our size from 15 to 19 members of Congress. While the State Legislature will not increase in numbers, remaining at 120 members of the House and 40 members of the Senate, it will be required, because of population shifts, to redistrict the boundaries for these legislative seats.

FLAMPAC was one of the first organized in Florida, having its beginning in 1949. We now have a substantial number of PACs operating in Florida, with at least two of these surpassing FLAMPAC in total dollars contributed. Accordingly, the FLAMPAC Board of Governors has developed the following goals to be implemented during the 1981-82 calendar year:

Goal One:

Improve the current FLAMPAC structure by:

- a. Developing a clear and detailed outline of responsibilities of FLAMPAC Board members and District Representatives to which all appointed should specifically agree.
- b. Development of local FLAMPAC committees that will serve as the operating arm of FLAMPAC at the local level for implementation of programs.
- c. Appointments should be for two-year terms, and open to all FLAMPAC members who demonstrate a willingness to invest their time and money in FLAMPAC programs.
- d. Increasing the role of the Membership and Political Education Committees in development of programs and goals within their areas of responsibility.

Goal Two:

Recruit maximum membership with particular emphasis on volunteers for campaign activity.

Goal Three:

Provide sufficient staff and supporting services for FLAMPAC to meet its 1981-82 campaign and membership goals.

Goal Four:

Establish and deliver a highly motivating theme message to all members of the medical community.

Goal Five:

Provide skill training. (Workshops and other vehicles on a regional and county basis will be scheduled in the Fall of 1981 to accomplish this.)

Goal Six:

Establish a reward and recognition system as a means to stimulate and maintain enthusiasm of volunteers.

*Francis C. Coleman, M.D.
FLAMPAC President
Tampa*

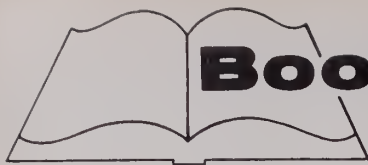
PHYSICIAN COOPERATION SOUGHT

To the Editor: The Medicaid Program is requesting the assistance of Florida physicians in the control of expenditures for the prescribed drug program. The budget analysis indicates that if the current rate of expenditure continues until June 1981, there will be a deficit of almost \$700,000 for the fiscal year 1980-81. The following means by which physicians can help reduce this deficit are well known to all of you, but are repeated for emphasis and your further consideration.

1. When a choice exists between a less expensive generic drug and its counterpart, select the generic.
2. When symptomatic treatment only is needed, prescribe a minimal supply of medication.
3. Prescribe no more medication for an acute condition than a course of treatment requires.
4. Prescribe monthly supplies and authorize refills for maintenance medication.
5. Be alert for duplicative prescriptions from other physicians. Review your patients' medication habits to detect duplication and lack of necessity.
6. Insist on effectiveness. If a placebo is needed, don't use an expensive one.

Although cost containment is the present thrust, the Medicaid agency is equally concerned with safety, effectiveness and availability. Only by cost control, however, can it be assured that your patients will be able to secure the treatment they truly need when they need it, and only you can provide that cost control effectively. Suggestions which any of you may have to assist in the better administration of the Medicaid Program will be welcomed and will be given careful attention. Please direct them through Don Nikolaus, M.D., Mease Clinic, Dunedin, Florida, who is the Chairman of the FMA Medicaid Committee and the physician representative on the Medicaid Advisory Council.

*James K. Conn, M.D.
State Medical Consultant, Medicaid
Tallahassee*



Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

Sex by Prescription by Thomas Szasz. 198 Pages. Price \$10.95. Doubleday & Company, Inc., New York, 1980.

Dr. Szasz is again showing his iconoclastic features. This man has written at least ten books which are "anti". He has made statements about psychiatrists' inability to properly testify in legal proceedings; he has made statements about the propriety of putting people in state hospitals; he has questioned the efficacy of psychiatric drugs; he has questioned the efficacy of all modalities of psychiatric treatment.

In his "expose" of sex therapy, he cites instances where the psychiatrist/physician/sex therapist is showing malevolent motives in his work or is misguided.

Many of his comments regarding the vagaries of sex therapy are quite correct. However, he tends to spoil it by picking on certain phrases or choices of words that sex therapists have used and picking them apart.

For those of you who are interested in the "cons" of sex therapy, this book would be interesting to read and I am sure would fortify whatever convictions you might have.

Organized psychiatry has many doubts about sex therapy and the untrained people who are in the field give us cause for alarm.

Dr. Szasz' comments about physicians having sex with their patients; this, of course, is a subject that gets brought up again and again.

This book should serve as a warning to any physician not to become engaged in any compromising situation with patients for fear of the traumatic outcome to him.

Robert G. Steele, M.D.

Dr. Steele is a psychiatrist practicing in Sarasota, and is Editor of The Florida Psychiatric Society *Newsletter*.

Every Woman's Health: The Complete Guide to Body and Mind by 17 Women Doctors. Consulting Editor D. S. Thompson, M.D. 776 Pages. Price \$19.95. Doubleday and Company, Inc., Garden City, N.Y., 1980.

When first confronted by the size of this book in relation to my time allotted for reviewing, I felt reluctant

to proceed, but curious. Why a book specifically about woman's health? Why written by 17 women physicians? The answer soon became apparent.

This book is divided into two parts, a second section which is a dictionary of commonly used medical terms or diagnoses for quick reference by the reader, and the primary text which is an authoritative and sensibly written group of chapters related to health, fitness, sexual states, conception — abortion, pregnancy — childbirth, gynecological disorders, emotional and social problems, and wise selection of one's physician. The authors move directly into their subject with enthusiasm, compassion, and forthright clarity. In contrast to the trite information available in the average news or magazine article, each chapter has a freshness of approach to practical information. How to look objectively at problems, how to prepare oneself in advance for what could happen, what to ask — these are the approaches that each author takes.

One of the most interesting chapters was Dr. Dorothy Hicks' discussion of the development of the rape center at Jackson Memorial Hospital in Miami. She points out that the sources of increasing violence in our society are frustration, anger, and hostility. In the past 5 years the violent crimes of rape, child battery and spouse assault have increasingly revealed their prevalence. The basic understanding of the effects of these crimes upon their victims is imperative in order to return these persons to their normal activities and functions. The antecedent prejudices of family, society, and police against the victim as well as the offender are discussed. And the recognition of solutions to interpersonal tensions is considered in an effort to prevent the eruption of these violent crimes and to develop an appropriate attitude when offenders are brought to trial.

My conclusions on reviewing this book are; 1) it is well written and easy to read, 2) it is well organized for quick referral, and 3) most readers, both male and female, would find it a liberal and open minded book that tells things as they are in life. There are no sermons and no old wives tales.

Rose London, M.D.

Dr. London is a cardiologist practicing in Miami Beach. She is also a past president of the Florida Society of Internal Medicine.

Atlas of Bedside Procedures edited by Thomas J. Vander Salm, M.D. 408 Pages. Illustrated. Price \$18.95. Little Brown and Company, Boston, Massachusetts, 1980.

This atlas was conceived by the surgical service of the University of Massachusetts Hospital as a resident teaching manual. The format is an excellent one, with a description of the indications for each of the procedures illustrated and an outline of all the equipment necessary to perform it. The steps of each procedure are then sequentially outlined and illustrated nicely with simple line drawings. The potential complications of each procedure are briefly discussed. The authors do not discuss the management of these complications, however, perhaps a weakness of this publication. At the end of each section there is an excellent selected and annotated bibliography. The procedures illustrated in this atlas range from the very common (i.e., subclavian catheterization, endotracheal intubation, thoracentesis, and liver biopsy) to the more esoteric (cervical pharyngostomy, insertion of a transvenous pacemaker, and bone marrow biopsy). On the whole, this is a unique and well constructed manual and one can find little argument with the methods illustrated. It certainly deserves a place in any medical library and would be extremely useful if kept in the patient care area. It is not the type of volume that every physician need own, but most could benefit from consulting it.

Bradley M. Rodgers, M.D.

Dr. Rodgers is Professor of Surgery and Pediatrics, Associate Chief, Division of Pediatric Surgery, University of Florida, Gainesville.

Clinical Gastrointestinal Immunology, Thomas, H. C. and Jewell, D. P. 264 Pages. Price \$41.00. Blackwell Mosby Book Distributors, St. Louis, Mo., 1979.

Gastrointestinal immunology is a rapidly developing field which is difficult to keep abreast, especially for those not involved in basic research. Clinical gastrointestinal immunology is an up-to-date, readable, concise and accurate review of this topic. The first chapter provides an introduction to the immune system and this followed by chapters on the immunologic defense of the gastrointestinal tract and the influence of the liver on the immune response. The last eleven chapters deal with specific disease processes including celiac disease, inflammatory bowel disease, acute viral hepatitis and chronic active liver disease. Particularly useful features include the

presence of a large number of clear tables, a glossary of unfamiliar terms and extensive references at the end of each chapter. The major emphasis of this book is placed on the relationship of immunology to the pathogenesis of gastrointestinal disease in man. A large amount of both experimental and clinical data is synthesized and put into perspective. It should be noted, however, that detailed information on therapy of these disorders is not provided.

This book is recommended for gastroenterologists and hepatologists. It should also be useful for research workers exploring the immunologic aspects of gastrointestinal disease.

Patrick G. Brady, M.D.

Dr. Brady is Associate Professor of Medicine at the University of South Florida.

Breast Self-Examination by Albert Milan, M.D. 125 Pages. Price \$3.50. Workman Publishing, New York, 1980.

Dr. Milan's excellent little book on breast self-examination is valuable for the woman who wants to know why and how to do the examination. The chapters on anatomy and physiology, in clear simple language also explain the significance of common findings, both normal and abnormal which can help to avoid a panicky reaction while encouraging prompt followup of an abnormality. The section on examination in the bath or shower, not usually stressed in other publications, is particularly valuable. My teen-age daughter found the book easily understandable, well written, and the instructions quite clear.

For the woman who is doing breast self-examination, this book provides an excellent guide and will probably improve her technique. Unfortunately, the woman who is not examining her breasts on a regular basis and who is not already familiar with the Cancer Society's little booklet, is unlikely to pick up this book on the bookstore shelf.

Lawrence H. Jacobson, M.D.

Dr. Jacobson is a Radiotherapist at Mt. Sinai Medical Center, Miami Beach.

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
 Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
 Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
 Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacterio. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults. †depending on severity

Books Received

Receipt of the following books is acknowledged.

Microbial Diseases — Notes, Reports, Summaries, Trends compiled by Carl W. May. 322 Pages. Paperback. Illustrated. William Kaufmann, Inc., Los Altos, California, 1980.

Consumer's Guide to Cosmetics by Tom Conry. 376 Pages. Illustrated. Paper. Price \$3.95. Doubleday & Company, Inc., New York, 1980.

Mesmerism, A Translation of the Original Medical and Scientific Writings of F. A. Mesmer, M.D. 180 Pages. Price \$11.50. William Kaufmann, Inc., Los Altos, California, 1980.

The Doctors' Case Against the Pill by Barbara Seaman. 239 Pages. Paper. Price \$6.50. Doubleday & Company, Inc., New York, 1980.

Inadvertent Modification of the Immune Response edited by I. M. Asher, Ph.D. 319 Pages. Illustrated. Paper. The Office of Health Affairs, FDA, 1978.

Born at Risk by B. D. Cohen. 212 Pages. Illustrated. Price \$9.95. St. Martin's Press, New York, 1980.

The Future of Pharmaceuticals by Clement Bezold, Ph.D. 142 Pages. John Wiley and Sons, New York, 1981.

The Physician's Business Manual by Richard M. Klass, M.B.A. 294 Pages. Appleton-Century-Crofts, New York, 1981.

A Miracle to Believe In by Barry Neil Kaufman. 313 Pages. Price \$12.95. Illustrated. Doubleday & Company, Inc., Garden City, New York, 1981.

Liver Biopsy Interpretation by Peter J. Scheuer, M.D. 260 Pages. Illustrated. Bailliere Tindall, London, 1980.

Profile of the Residency Trained Family Physician in the United States 1970-1979 edited by John P. Geyman, M.D. 68 Pages. Price \$12.00. Appleton-Century-Crofts, New York, 1981.

This publication
is available in microform.

University Microfilms International

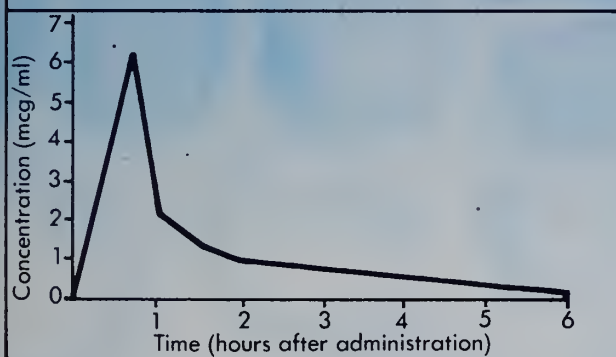
300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on $T^{1/2}$ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Wyeth Laboratories • Philadelphia, Pa 19101



Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.[†]

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

[†]Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW
NAME

MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

MAY

Neurology-Neurosurgery Seminar 1981: Update for the Primary Care Physician, May 2-3, The Hilton Inn, Gainesville. For information: Joseph C. Cauthen, M.D., 4040 Newberry Road, Suite 1100, Gainesville 32601.

Clinical Nuclear Medicine Imaging, May 2-3, Univ. of Mississippi Medical Center, Jackson, Mississippi. For information: Dr. C. Jay Kees, Division of Continuing Health Professional Education, Univ. of Mississippi Medical Center, 2500 N. State Street, Jackson, Mississippi 39216.

Scientific Programs for Department of Family Practice, May 6, Naples Community Hospital, Auditorium, Naples. For information: Louis Dvorch, M.D., Box 2507, Naples, FL 33940, Attn. Helen Taylor.

Cardiology for the Primary Care Physician, May 7-9, Hyatt Regency, Sarasota. For information: Leonard S. Dreifus, M.D., Joel Morganroth, M.D., Lankenau Hospital, Philadelphia, PA 19151.

Seventh Annual Advances in Neonatal and Pediatric Respiratory Care, May 7-9, Sheraton Sand Key Hotel, Clearwater Beach. For information: Robert Cavanaugh, M.D., All Children's Hospital, 801 6th Street South, St. Petersburg 33701.

ECG Interpretation and Arrhythmia Management, May 8-10, Don Cesar Hotel, St. Petersburg. For information: Stephen E. Mattingly, 64 Inverness Drive, East, Englewood, Colorado 80112.

Conferences in General Medicine and Family Practice, May 11, International Hospital, Miami. For information: Alfredo Crucet, M.D., and Heather Childs, ARNP, University of Miami, Department of Family Medicine, P.O. Box 016700, Miami 33101.

Conferences in General Medicine and Family Practice, May 13, International Medical Center, HMO, Miami. For information: Alfredo Crucet, M.D., and Heather Childs, ARNP, P.O. Box 016700, Miami 33101.

Antibiotics on Respiratory Infections, May 14, Abbey Hospital, Conference Room, Coral Gables. For information: Anthony J. Pellicane Sr., M.D., 5190 S.W. 8th Street, Coral Gables 33134.

Human Sexuality, May 14-16, Gainesville Hilton, Gainesville. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Personality Adaptation Theory Used in Working With Couples and Families, May 22, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Fort Walton Beach 32548.

Master Approach to Cardiovascular Problems, May 29-31, The

Contemporary Hotel, Walt Disney World, Lake Buena Vista. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

JUNE

Scientific Programs for Department of Family Practice, June 3, Naples Community Hospital, Auditorium, Naples. For information: Louis Dvorch, M.D., Box 2507, Naples 33940, Attn. Helen Taylor.

Eighth Annual Florida Perinatal Conference, June 5-6, Holiday Inn International, Orlando. For information: R. J. Boothby, M.D., 5720 Atlantic Boulevard, Jacksonville 32207.

14th Annual Physicians Workshop in Electrocardiography, June 9-16, Los Lebreros Hotel, Seville, Spain. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg, 33705.

Annual Homecoming Symposium (Psychiatry), June 12-13. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

6th Annual Suncoast Pediatric Conference, June 14-17, Sheraton Sand Key, Clearwater Beach. For information: Frank J. Cozzetto, M.D., c/o All Children's Hospital, Development Department, 801 6th Street South, St. Petersburg 33701.

FAFP 32nd Annual Scientific Assembly, June 17-21, Daytona Hilton, Daytona Beach. For information: Guy T. Selander, M.D., 1736 University Boulevard South, Jacksonville 32216.

Wyeth Autotutors, Florida Academy of Family Physicians 32nd Assembly, June 18-20, Daytona Beach Hilton Hotel, Daytona Beach. For information: Guy T. Selander, M.D., 1736 University Boulevard, South, Jacksonville 32216.

13th Family Practice Review, June 22-26, The Breakers, Palm Beach. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Cardiac Ischemia and Arrhythmias: Current Concepts for Diagnosis and Treatment, June 26-28, Dutch Inn, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood, Colorado 80112.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, (7th Annual Review Course), Aug., Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

MEDICAL OPHTHALMOLOGIST wanted for busy practice. No refraction or contact lens fitting. Ideal location in East Coast of Florida. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

FLORIDA — Well established East Coast Group seeks fourth Pediatrician. Salary leading to early partnership. Send C.V. Reply C-1028, Post Office Box 2411, Jacksonville, Florida 32203.

WEST COAST FLORIDA: General Internist (with or without subspecialty). Rapidly growing multispecialty group. New facility, full ancillary services, adjacent ultra-modern hospital. Excellent remuneration and fringe benefits. Send C.V. to C-1031, Post Office Box 2411, Jacksonville, Florida 32203.

INTERNIST — CARDIOLOGIST: Three man practice seeks badly needed associate with immediate availability possible. Excellent opportunity in well established Internal Medicine, non-invasive Cardiology practice in Coral Gables, Florida. Reply C-1036, Post Office Box 2411, Jacksonville, Florida 32203.

WELL TRAINED Family Practitioner or Internist needed to join staff of a Family Medical Center in Jacksonville, Florida. Excellent opportunity for professional and economic growth. Respond with CV to: Susan Masterson, Emergency Medical

Services Associates, Inc., 8200 W. Sunrise Boulevard, Building C, Plantation, Florida 33322, or phone (305) 472-6922.

FULL-TIME CAREER-ORIENTED Emergency Physicians to work in busy Dade County Emergency Departments with an old, established group. Liberal salary with bonus incentives. Send C.V. to: Emergency Physicians, Post Office Box 160429, Miami, Florida 33116.

SURGEON — General, Vascular, Thoracic — Non-cardiac — needed as independent or associate in small town bordering Orlando. Send CV and references to C-1044, P.O. Box 2411, Jacksonville, Florida 32203.

THE UNIVERSITY OF FLORIDA, Jacksonville Division, is seeking qualified and experienced candidates for the position of Chairman, Department of Family Practice, and Director of the residency program, located at St. Vincent's Medical Center. The residency is fully accredited and well-established. Students are assigned and there is strong community and staff physician support. The Chairman will provide leadership in the areas of teaching, administration, curriculum management, patient care, and research. Board certification in Family Practice is desirable. Academic appointment at the level of Assistant /Associate Professor, commensurate with qualifications. Excellent salary and fringes. Please forward Curriculum Vitae and references by the recruiting deadline of April 1, 1981 to: Mr. Glenn Flake, Assistant Administrator for Medical Affairs, St. Vincent's Medical Center, Post Office Box 2982, Jacksonville, Florida 32203. Equal Employment/Affirmative Action Employer.

FAMILY MEDICINE — Tampa Bay area. Independent practice or expense sharing. Booming area. Contact: Walter Lane, M.D., 13301 North Dale Mabry, Tampa, Florida 33624. Phone (813) 962-0355.

THE UNIVERSITY OF FLORIDA is seeking an M.D. for a position as Medical Director of the Blood Bank at the level of instructor of Pathology. The major responsibilities include supervising the Immunohematology, Hemotherapy and Paternity Testing services at the 450 bed

teaching hospital; teaching residents, medical and health related professions students; and developing independent research. A major goal is the development of a comprehensive automated information system for the Blood Bank. Experience in laboratory management and data systems is highly desirable. Salary is negotiable with a starting date of July 1, 1981. Forward applications by deadline of May 1, 1981 to: Juan C. Scornik, M.D., Assistant Professor, Department of Pathology, Box J-275, JHMH, University of Florida, Gainesville, Florida 32610. An Equal Employment/Affirmative Action Employer.

LOCUM TENENS — Diagnostic, Nuclear, Ultrasound, Radiology Department. Coastal Northeast Florida — Summer and/or Fall months — May lead to association. Contact J. L. Castillo, M.D., P.A., Post Office Drawer N, Fernandina Beach, Florida 32034.

WANTED — Medical Director for County Health Unit Chief Administrator for staff of 40, full-range public health programming. Florida licensed. Excellent fringe benefits. Contact: E.C. Prather, M.D., (904) 487-2546, Florida Department of HRS. An Equal Opportunity/Affirmative Action Employer.

PHYSICIAN WANTED to share office expenses with internist. Brand new office in Boca Raton, Florida. Reply C-1045, Post Office Box 2411, Jacksonville, Florida 32203.

INTERNIST TO JOIN established partnership practice, Miami Shores, starting July 1981. Curriculum vitae to: Medical Business Consultants, Suite 309, 9999 N.E. 2nd Avenue, Miami Shores, Florida 33138.

BOARD CERTIFIED/Eligible internist interested in Cardiology or rehabilitation medicine: Join established group in Miami Beach. Involvement includes activity in private practice and participation in a health oriented clinic. No investment necessary. Attractive salary and fringe benefits. Florida license required. Call or write: T. Walker, 1688 Meridian Avenue, Miami Beach, Florida 33139, (305) 538-4448.

Situations Wanted

UROLOGIST, 30, American graduate, Board eligible. Excellent training at large New York City Medical Center. Available July 1981. Seeks group practice or partnership. Call (212) 876-5175.

GENERAL, COLON AND RECTUM SURGEON, trained in Colonoscopy, Board eligible, 35, seeks position in Florida to practice either one specialty or both. Speaks Spanish fluently. Available October 1981. Contact: Luis F. Espallat, M.D., 1517 Texas Avenue, Homestead AFB, Florida 33039. Phone (305) 257-2870.

JOHN L. DRISCOLL, M.D. — General Surgery Resident; CMDNJ/Board Eligible; holds current Florida Medical Licensure; seeking General Surgery practice, group or partnership; available July 1981. Reply: 631 Avenue E, Bayonne, New Jersey 07002.

FMG, 33, cooperative; Florida licensed; completing Adult/Pediatric, Allergy/Immunology Fellowship June 1981. Board eligible Pediatrics, Allergy/Immunology. All practice types in Florida considered. Reply C-1040, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST SEEKING immediate practice opportunities in Dade/Broward County. Will consider part-time, E.R., or buying practice. Write: Sailesh M. Dave, M.D., P.O. Box 69-3005, Miami, Florida 33169.

PATHOLOGIST — 36 years. University and broad experience in 800 bed hospital. Certified Anatomic and Clinical Pathology. Desires relocation in Florida. Prefer hospital based or group position in Gulf Coast area. Reply: C-1046, Post Office Box 2411, Jacksonville, Florida 32203.

PEDIATRICS - ALLERGY. 40 years: Duke graduate; energetic. Desires Associate/Partnership or purchase of practice. Florida license. Reply: A. Kramer, M.D., F.A.A.P., 71 West River Street, Wilkes-Barre, Pennsylvania 18701.

GENERAL SURGEON, 35, University trained, Board certified, seeks private practice, all situations and locations considered. Reply: John Robert Ward, M.D.,

2533 Hilton Court, Augusta, Georgia 30900.

GENERAL PRACTITIONER Florida license, desires full time position solo or group in Clearwater, St. Petersburg, Tampa or Daytona Beach. Telephone (613) 226-1498.

FAMILY PRACTITIONER, 37, residency trained, Board certified, Florida license, bilingual, seeks private practice or group opportunity in Coastal or Central Florida. Would also consider joining or establishing Weight Control Clinic. Available Summer or Fall 1981. Reply: Box 231, Alta Loma, California 91701.

INTERNIST, BOARD Eligible, Florida licensed. Floridian desires relocation in Florida. University trained; one year clinical pulmonary disease. Academic background. Experience in solo and group practice and corporate medicine. Available about July 1, 1981. For CV and information contact: Harry A. Edwards, M.D., days — (615) 327-2520, evenings — (615) 446-6714. Rt. 2, Box 41, Burns, Tennessee 37029.

33 YEAR OLD M.D. interested in solo/group general practice in medium size or small community in Florida. Experienced as Emergency Room physician for three years in prestigious Philadelphia hospital. Reply Kirit J. Shah, M.D., 136 Thornhill Road, Cherry Hill, New Jersey 08003.

INTERNIST — CARDIOLOGIST, ABIM certified, experienced in Cardiac Catheterization, 2D, Nuclear CCU, open hearts, pacemakers, teaching and research. Available July 1981. Reply: C-1047, Post Office Box 2411, Jacksonville, Florida 32203.

Practices Available

MEDICAL OFFICE AVAILABLE JULY 1981, 475 Biltmore Way, Coral Gables; 1,000 square feet. All furniture, fixtures and equipment ready for sale intact to lessee. Functional, tasteful office, "ready to go" for specialist or generalist or new physician. Call 443-8767 or 665-1713 after 5.

FOR SALE: PHYSICIAN'S General

Practice, well established, including all office equipment in beautiful Orlando, Florida, adjacent to Florida Hospital. Call (305) 644-4053, evenings.

FAMILY PHYSICIAN wanted to step in and take over established Family Practice. Excellent location. Open door and begin active practice. Convenient, helpful terms. I will stay in Jacksonville as full-time faculty with Family Practice Residency. Call collect, Craig Ray, M.D., (904) 737-1848.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

DURANGO, COLORADO: Magnificent 35 to 40 acre Ranchsites on 2,000 acre ranch. Only a few left. From \$3,000 per acre. Will finance. Incredible hunting on property. Year 'round recreation, fabulous skiing. Russell Yates, Beaver Creek Ranch, P.O. Box 2433, Durango, Colorado 81301. Telephone (303) 259-2680.

WITHLACOOCHIE RIVER — Heavily wooded half acres of swift running clean water, Gulf access. Exclusive area, first time offered. Vacation now, retire later. Pictures available. Contact Lona Lubin, Century 21, We Realty, Inc., 777 Pasadena Avenue South, St. Petersburg, Florida 33707. (813) 381-0707 or (813) 343-0680.

MEDICAL FACILITY downtown Orlando near all hospitals. 1493 feet includes X-ray, exam rooms, etc. Free use of \$60,000 worth of medical equipment. Sacrifice \$900 month. (305) 425-2843 or 351-5885.

ORLANDO, FLORIDA — Lease: Brand new construction, medical-dental-professional. Prestigious location in Tusawilla Community. Interior ready to be designed to your specifications. 1,000 to 2,000 square feet suites available. Contact: Ray Chimento, Box 9168, Union Park, Florida 32817. (305) 282-1111.

Services

GOLD AND SILVER — Inflation Hedge and only real money. Buy or sell. Contact: Au, M.D. — E.K. House, M.D., 629 West Broad Street, Brooksville, Florida 33512.

THE PAUL T. COLLINS Company of Gainesville and Daytona Beach, Florida is a professional business management and consulting firm to physicians. We fully organize new practices and streamline existing ones to increase dramatically the profitability of medical practices while eliminating the business worries of the practice. For further information respond to: 6483 Newberry Road, Suite C, Gainesville, Florida 32605 or phone (904) 372-7999.

Equipment

SEVERAL MICROSCOPES for sale — One Luminiscope, binocular B & L, Monocular B & L. These and others are like new. Call: (904) 781-1180, Jacksonville, Florida.

Miscellaneous

ANTIQUE PLAYER PIANO — with 50 rolls, restored and refinished. A fine antique. Plays and sounds great! Your choice of either an upright or baby grand. Wayne Edmonston, (904) 268-2775, 2177 Bishop Estates Road, Jacksonville, Florida 32223.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Col, 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

When
Impotence
is due to androgenic deficiency.

Android® 5^{Buccal} / 10^{Oral} / 25^{Oral}
Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-pubertal cryptorchidism.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to endrogen deficiency. 3. Impotence due to endrogenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED** — 10, 25 mg. in bottles of 60, 250. Rx only.

Write for new double-blind study reprints and samples

BRUNNEN THE BROWN PHARMACEUTICAL CO., INC.
2500 West 50th Street, Los Angeles, California 90067



Advertisers

Anderson-Clayton Foods		Numismatic Investments of Florida	
New Age Sandwich Slices	244	Investments	254
Boots Pharmaceuticals		Pennwalt Pharmaceuticals	
F.E.P. Creme	254a	Zaroxolyn	318a
Su-Ton	254a	Purepac Pharmaceuticals	
Twin-K	254a	Generics	259
Twin-K-Cl	254a	Roche Laboratories	
Bristol Laboratories		Valium	238
Tegopen	252	Bactrim	335
Brown Pharmaceuticals		Librax	254a
Cerebro-Nicin	314	Sequoia Group, Inc.	
Lipo-Nicin	315	Medical Systems	254a
Android	333	Southeast Banking	
Burroughs Wellcome		P.I.P.E.R.	241
Zyloprim	250	Smith Kline and French	
Neosporin Topicals	254a	Dyazide	318a
Convention Press		University of Florida	
Service	322	Meeting	240
Florida Medical Foundation		The Upjohn Company	
Citrus	249	Motrin	318a
Florida National Banks		Upjohn Healthcare Services	
Service	249	Service	254a
Geriatric Pharmaceutical Co.		Wetzel	
B-C-Bid	246	Service	258
Eli Lilly & Company		Willingway Hospital	
Cecilor	317	Service	260
Merrell-National		Wyeth Laboratories	
Bentyl	320	Cyclapen	328
North Ridge General Hospital			
Meetings	240, 257		

Florida Medical Association Officers and Council Chairmen

Officers

T. Byron Thames, M.D., Orlando, President
 Sanford A. Mullen, M.D., Jacksonville, President-Elect
 Gerold L. Schiebler, M.D., Gainesville, Vice President
 Robert E. Windom, M.D., Sarasota, Secretary
 J. Russell Forlaw, M.D., Boynton Beach, Treasurer
 Richard S. Hodes, M.D., Tampa, Immediate Past-President
 James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
 Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
 W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
 Louis C. Murray, M.D., Orlando, Legislation and Regulations
 William W. Thompson, M.D., Ft. Walton Beach, Health Care Financing
 Joseph T. Ostroski, M.D., Miami, Medical Services
 Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
 Dick L. Van Eldik, M.D., Lake Worth, Specialty Medicine

FLORIDA MEDICAL ASSOCIATION



MAY 1981 • VOL 68 • NO. 5



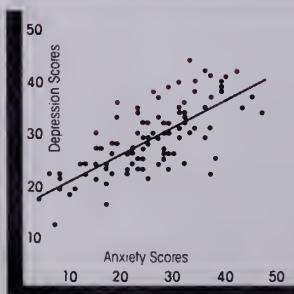
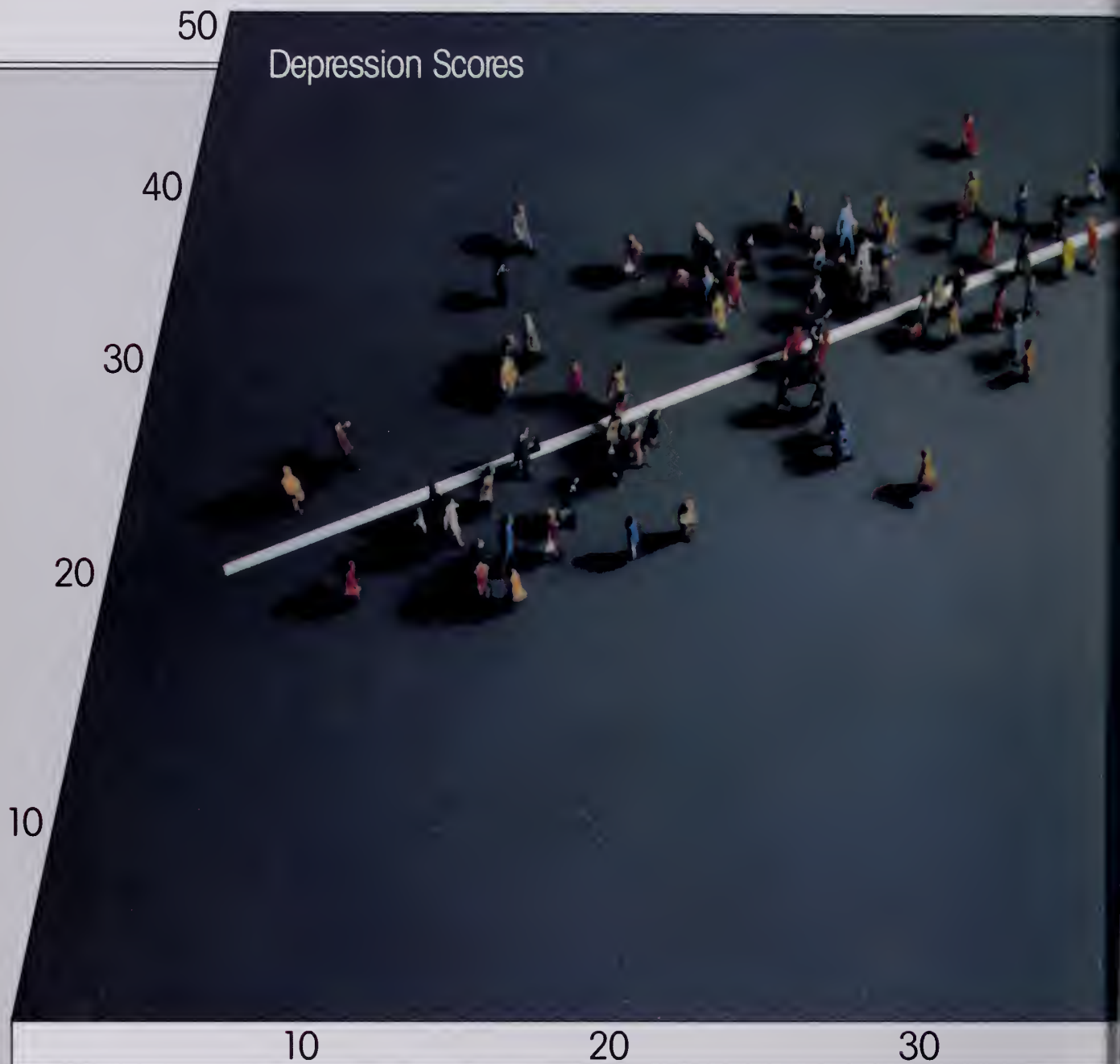
Tc^{99m} HIDA

CHOLESCINTIGRAPHY

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JUN 1 1981

Anche Penard

FOR THE 7 OF 10 NONPSYCHOTIC



Clear correlation between anxiety and depression³

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

³Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics* 11:438-441, Sept-Oct 1970.

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS^{1,2}

Most depressed patients are also anxious. . .

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.^{1,2} One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.³ As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.⁴ Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.⁵ Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. 2. Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry* 35:1359-1365, 1978. 3. Claghorn J: The anxiety-depression syndrome. *Psychosomatics* 11:438-441, 1970. 4. The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry* 137:1163-1172, 1980. 5. Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology* 61:217-225, 1979.

Anxiety Scores

50

In moderate depression and anxiety

Limbitrol®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquillizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Packs of 50.



THE COMPLETE INVESTMENT PORTFOLIO INCLUDES RARE COINS.

Rare coins can be an extremely rewarding way to diversify your investment portfolio. Quality U.S. rare coins provide a stable inflation hedge and have appreciated over the last decade at a rate averaging over 57% annually. Coin investing is the smart, sophisticated, and highly profitable way to complete your investment portfolio.

If you've been considering rare coins, you need professional guidance and expert advice. We are one of the largest firms in the country specializing in quality United States Rare Coins. We can also assist you in establishing coin funded Keogh, IRA, or Corporate Retirement Plans.

Serious inquiries invited.

(305) 373-3001

By appointment only.



**NUMISMATIC
INVESTMENTS
OF FLORIDA**

Brickell Center, Suite 701,
799 Brickell Plaza
Miami, Florida 33131

Members:

Professional Numismatists Guild
& American Numismatic Association



ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

MAY 1981 • VOL 68 • NO. 5 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.
E. Charlton Prather, M.D.

Assistant Editors

James K. Conn, M.D.
Lee A. Fischer, M.D.
Edward Pedrero Jr., M.D.
J. Lee Dockery, M.D.
(from Board of Governors)
Francis C. Coleman, M.D.

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Susan L. Milhoan

Consulting Editorial Staff

William A. Alonso, M.D.	Karl J. Kramer, M.D.
Fuad S. Ashkar, M.D.	R. G. Lacsamana, M.D.
Hubert A. Aronson, M.D.	Richard F. Lockey, M.D.
Thomas D. Bartley, M.D.	Philander D. Morgan, M.D.
Robert L. Batey, M.D.	George Morris, M.D.
Pierre J. Bouis Jr., M.D.	George A. Nader Jr., M.D.
Ms. Deborah B. Wilbur	Richard S. Panush, M.D.
William T. Branch, M.D.	R.A. Penalver, M.D.
Miguel A. Brito, Jr.	John K. Petrakis, M.D.
Elmer B. Campbell, M.D.	Phillip B. Phillips, M.D.
Manuel L. Carbonell, M.D.	Michael R. Redmond, M.D.
Ronald W. Case, M.D.	Albert L. Rhodon, M.D.
Louis E. Cimino, M.D.	James F. Richards Jr., M.D.
Charles Craig, M.D.	Arvey I. Rogers, M.D.
R. Jay Cummings Jr., M.D.	William J. Romanos Jr., M.D.
Raul de Velasco, M.D.	Lees M. Schadel, M.D.
James E. Deming	Frederick W. Schert, M.D.
Pablo Enriquez, M.D.	Guy T. Selander, M.D.
Robert F. Feltman, M.D.	Roberto A. Sosa, M.D.
Richard Feinstein, M.D.	John Stone, M.D.
Lawrence M. Fishman, M.D.	Robert H. Threlkel, M.D.
John W. Glotfelty, M.D.	Benjamin E. Victorica, M.D.
Allan L. Goldman, M.D.	Norman H. Wasserman, M.D.
Henry L. Harrell, M.D.	Thomas M. Wiley, M.D.
Allan Herskowitz, M.D.	Charles D. Williams, M.D.
James T. Howell, M.D.	Governor M. Witt, M.D.
Troy H. Hutchinson, M.D.	Frederic C. Wurtzel, M.D.
Rubin Klein, M.D.	

Subscription Rate: \$15.00 per year, single copy. \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917: authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

- 357 Experience With Tc 99m HIDA in the Diagnosis of Acute Gallbladder Disease in Columbia County, Florida
Ricardo Bedoya, M.D.
- 361 Florida Statewide Cancer Data System
James T. Howell, M.D., M.P.H., R. Michael Yeller, M.D., and Douglas Palin, M.S.
- 365 Disseminated Coccidioidomycosis With Respiratory Failure Presenting in Florida
W. Giles Allen, M.D., Gerald N. Olsen, M.D., and Bruce M. Yergin, M.D.
- 369 Increased Risk of Bacterial Endocarditis With Idiopathic Hypertrophic Subaortic Stenosis
John W. Klemme, M.D., and John F. Breen, M.D.

Special Articles

- 371 Physician Extenders in Florida
Richard J. Feinstein, M.D.
- 375 Penicillinase-Producing Neisseria Gonorrhoeae in Florida
James T. Howell, M.D., M.P.H., and Jack E. Wroten, M.D.
- 377 Summary of Consensus Development Conference on CEA

Editorials

- 345 The "Routine" Autopsy — A Community Hospital Pathologist's View
Richard S. Aronsohn, M.D.
- 346 Human Experimentation Committee vs. Edward Jenner
Craig S. Kitchens, M.D.

Organization

- 381 T. Byron Thames, M.D., A Year of Leadership
Louis C. Murray, M.D.

Departments

- 343 President's Page
A Final Message
T. Byron Thames, M.D.
- 387 Medical News Around the State
- 391 Book Reviews
- 393 Books Received
- 395 Meetings
- 398 Classified Advertising
- 402 Index to Advertisers
- 402 FMA Officers and Council Chairmaen

Cover

This month's cover was produced by Andre Renard, M.D., a plastic surgeon practicing in Jacksonville. The work represents some of the progress which has been made in the diagnosis of gallbladder disease over the years and highlights the lead article concerned with the use of a new radiologic technique in the diagnosis of acute gallbladder disease. The top portion shows some of the anatomical sketches of the liver and abdomen made by Leonardo da Vinci in the 16th century accompanied by his characteristic mirror-image Latin. The bottom portion shows the appearance of a normal gallbladder seen using Tc 99m HIDA.

A TOTALLY NEW DELIVERY SYSTEM TO HELP REDUCE THE FEAR OF ANGINAL ATTACKS

Round-the-clock
protection with

ISO-BID

(ISOSORBIDE DINITRATE)

40 mg. capsules ... twice-a-day dosage

Controlled sustained release of ISO-BID's isosorbide dinitrate through micro-dialysis diffusion can help reduce frequency and intensity of anginal attacks. This in turn can minimize patient's fear of attacks, and dependence on nitroglycerin.

Unlike ordinary sustained release products, ISO-BID releases isosorbide dinitrate at a smooth, continuous, predictable, controlled rate to provide for up to 12 hours of therapeutic activity. Micro-dialysis is dependent only upon the presence of fluid in the G.I. tract and not on pH or other variables. ISO-BID is particularly advantageous in the prevention of nocturnal angina.

DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Some patients may require higher dosage levels. In these patients, dosage should be titrated, and they may require two ISO-BID capsules b.i.d. Not intended for sublingual use. Consult product brochure before prescribing.

THERAPEUTIC FOOTNOTE: IN TREATING ANGINA . . . FAILURES MAY RESULT FROM INADEQUATE DOSAGE. Reports in the literature indicate the usefulness of higher dosage levels of isosorbide dinitrate.^{1,2}

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

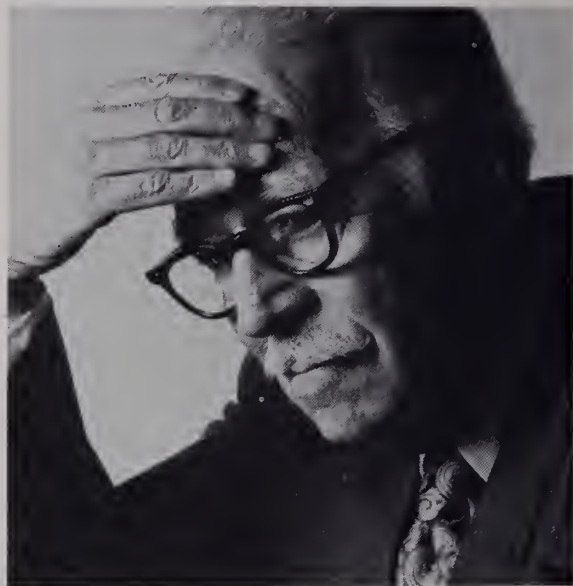
CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness

and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.



SAMPLES AND LITERATURE AVAILABLE.

GERIATRIC PHARMACEUTICAL CORP. BOX 68. FLORAL PARK, NEW YORK 11001
PIONEERS IN GERIATRIC RESEARCH
DEVELOPERS AND SUPPLIERS OF CEVI-BID • GER-O-FOAM • TESTAND-B

1. Shane, S.J.: Canadian Family Physician, November 1973. 2. Lemberg, L.: Practical Cardiology, February 1976.





President's Page

A Final Message

This is the last President's Page I will be privileged to write as your President. It seems only a few months ago that you honored me by electing me to serve in this capacity. I can truly say this year has sped by. The FMA has been active and successful in many fields, but we have a number of tasks still to be undertaken or completed. I have no doubt that your incoming President, Dr. Sanford Mullen, will handle them ably and energetically.

This time spent in your service has been the most rewarding experience of my half century of living. We are blessed with a splendid staff of personnel in the FMA who help keep us on course and who enable us to carry out the wishes of the membership as expressed by the House of Delegates. I have enjoyed the opportunity to cement my personal relationship with each of them and I am a better man for having worked with them. Whatever has been accomplished this year is due in a large measure to the staff and their interrelationship to your officers and Board of Governors who have worked hard and diligently to carry out your desires.

Many of you have assisted us in the various committees and councils of the FMA. You, too, have sacrificed many of your weekends and leisure hours in working for your profession and your colleagues. You have attended the editorial tour meetings, the Leadership Conference, served as Doctor of the Day, been effective Key Contact physicians, served as public relations ambassadors to the news media and made all of us stand a little taller with the public in other countless ways.

You have allowed your wives to help us with our Impaired Physician Program, FLAMPAC, AMA-ERF, Legs Alert, and many other worthwhile projects. When she was away for a weekend meeting, you filled in the gap as she does for you. We are grateful for both your efforts.

I have had the opportunity to publicly and privately thank many of you personally in Hollywood in April at the Annual Meeting. For those I missed, let me take this opportunity to thank each of you who are members of the FMA for your support and friendship and interest which have helped me this year. Whether as council chairman, or committee chairman, or member of either; as a county medical society officer; or specialty society officer; or as a concerned member who wrote or called or attended some meeting at which I spoke; or someone who read *The Journal* and discussed with your colleagues the issues that affect each of us in medicine, you have all served this year, many without honors or titles. Let me say thank you to each and everyone for the memories which I take with me. In years to come they will ever remain clear and valued by me.

I look forward to continuing to work with each of you for our common goals in Florida through the Florida Medical Association and in the country through the American Medical Association. Our goals for our patients are noble, our purpose is steadfast, our courage and stamina unequalled. We shall meet the challenge and our nation will be the winner.

T. Byron Hammond

FROM DIETARY COMPLAINTS



"Too Bland"



"Tasteless"



"No Variety"



"Hard To Cook"



"Only
Cottage Cheese?"



"Daddy's
Dull Diet"

TO COMPLIANCE



INTRODUCING *New Age*TM SANDWICH SLICES

- 90% less cholesterol
- 75% less saturated fat

Now, New Age—a cheese substitute made with vegetable oil—provides the good taste of process cheese without its restrictively high cholesterol content.

New Age has 90% less cholesterol, 75% less saturated fat, yet provides all the protein, vitamins and minerals of process cheese... good news for all health-conscious patients!

AMERICAN
SWISS
SMOKEY
HOT PEPPER



*New Age*TM

is consistent with
the cholesterol-control,
low-fat recommendations
of the third edition of
**The American
Heart Association
Cookbook.**

The "Routine" Autopsy — A Community Hospital Pathologist's View

The Joint Commission on Accreditation of Hospitals abolished its requirement of a fixed autopsy percentage (25%) in the early part of the last decade. Since that time, there has existed a raging controversy amongst physicians over the present and future role of the autopsy in medicine. Without a doubt, the role of the autopsy will and should vary depending upon the type of hospital. I would like to express my personal views as a pathologist practicing in a medium sized community hospital. I am keenly aware of the fact that my opinions may differ considerably from those of my colleagues practicing in large academic centers where the autopsy is important for training residents and providing valuable data for investigative studies.

I would like to start out by stating that there is no place for the "routine" autopsy in a community hospital. A "routine" autopsy is one that is requested automatically or out of habit without considering the quality of information to be gleaned from the procedure. Some physicians are unaware that the Joint Commission on Accreditation of Hospitals has deregulated hospital autopsies, and continue to request the procedure primarily to satisfy statistical requirements. Others will request autopsies on patients in whom all clinically significant problems had been uncovered and resolved by extensive ante-mortem laboratory and radiological evaluation. The motives of the latter group are not clear to me. The autopsy is a sophisticated, time consuming, and expensive diagnostic procedure which must not be overutilized. Like other elaborate diagnostic procedures such as the CT scan or cardiac catheterization, autopsies should be performed only when indicated and never considered routine.

As suggested by Burrows,¹ if autopsies are to assist in clinical problem solving and serve as a yardstick for the assessment of quality medical care, there must be a combined effort on the part of clinicians and pathologists alike to select cases that will provide useful information. It is deceptive to look at autopsy percentages in a given institution as an indicator of quality medical care. Failure to autopsy a clinically puzzling case cannot be rectified by performing postmortem examinations on a large number of routine cases. In addition, a high percentage

of routine cases is merely a waste of valuable medical resources. A much more reliable indicator is the quality of autopsies performed and the extent to which clinicians and pathologists discuss cases both before and after postmortem examinations. This dialogue is the educational component which ultimately improves the quality of care.

One should look upon the autopsy as a form of consultation. The pathologist is aware of the limitations of the procedure, and on the basis of clinical data, he is often able to determine whether an autopsy will provide additional information to the clinician. The autopsy should be considered as part of the continuum of patient care. As with any consultation, the clinician should have definite objectives and questions to be answered prior to requesting an autopsy. An informal pre-autopsy conference is useful in conveying these objectives to the pathologist. Alternatively, a written consultation including pertinent clinical data and questions to be answered could be provided. The autopsy procedure can then be individually tailored to satisfy these objectives and increase the likelihood of answering the attending physician's specific questions.

The indications for performing an autopsy are quite variable. Most commonly, there is a need to establish correlation amongst various ante-mortem diagnostic modalities. In addition, autopsies are indicated to evaluate therapeutic regimens and surgical procedures, and to clarify clinical enigmas.

In my practice, I try to discuss the case with the attending physician both before and after the postmortem examination. I attempt to provide him with a timely report (less than 1 week). The report is usually "problem oriented"² and includes pertinent clinical pathological correlations which serve to explain ante-mortem clinical problems. If the final written report is delayed because of special procedures, a preliminary report is verbally communicated to the attending physician. A great deal of educational benefit is lost if discussion of the case and the final report is unduly delayed.

The continually rising cost of medical care is a constant concern of both physicians and patients alike. De-

pending upon the institution, the total cost per autopsy is approximately \$800.³ As a rule, the pathologist does not receive remuneration for this service, and much of the cost is absorbed by the hospital and included in its overhead. It is readily apparent that an autopsy is not only the ultimate diagnostic procedure, but is also one of the most expensive. This factor alone should deter overutilization.

In summary, the "routine" autopsy is an overutilization of valuable medical resources and creates an unnecessary work load on the laboratory and the pathologist, as well as a financial burden to society. At the same time, "routine" autopsies provide little to improve the quality of medical care. Autopsies are of educational benefit and improve the quality of medical care when

they are selected appropriately and there is good communication and rapport between pathologist and clinician.

References

1. Burrows, Stanley: The Postmortem Examination, Scientific Necessity or Folly? JAMA 233: 441-443, 1975.
2. Saladino, Andrew J.; Dailey, Mary L.: The Problem Oriented Postmortem Examination, Am. J. Clin. Pathol. 69:253-257, 1978.
3. Yesner, Raymond: Medical Center Autopsy Costs, Am. J. Clin. Pathol. 69:242-244, 1978.

Richard S. Aronsohn, M.D.
Pathologist
Jacksonville

"Human Experimentation Committee vs. Edward Jenner"

"I thank God that I did not accept anybody's opinion on this subject, but determined to put it to a thorough test with human beings in order to see what would happen . . . actual trial has proven that I was right . . ."

Walter Reed commenting on his triumph over yellow fever.

From time to time, those interested in clinical investigation of human subjects find themselves face to face with the Human Experimentation Committee. Each step of one's protocol must be defended and rightly so. It is through these mechanisms that the safety of subjects is monitored and the experiment is examined such that even small risk to patients is justified by the anticipated benefit of a well-designed study.

Notwithstanding, occasionally one finds himself defending minutiae such as the risk of drawing blood. The mind of this investigator occasionally drifts away from the subject at hand during such meetings and I fantasize meetings of the Human Experimentation Committee with clinical investigators of the past. This fantasy has materialized in the form of the following letters depicting the discourse between the local Human Experimentation Committee and Edward Jenner as he was on the verge of revolutionizing infectious disease, clinical investigation, and, perhaps, the course of human history. Similar stories could be fabricated concerning the time Ambroise Pare ran out of boiling oil on the battlefield and

discovered that wounds which were not treated with boiling oil did better than those so treated. At that time, Pare obviously was deviating greatly from "standard accepted medical practice." No doubt, J. Marrion Sims would now have difficulty performing his initial gynecologic surgery although such was quite acceptable in 1845. Present day health care consumer groups would no doubt think that William Beaumont was taking advantage of Alexis St. Martin. I can also imagine the receipt of the application of Louis Pasteur (a chemist) to treat with an extract of rabid dog brain humans who had been bitten by a rabid dog.

The point of all this is that progress in the diagnosis and treatment of human disease requires the combination of chance, intellect, insight, luck, and the tenacity to go through with what needs to be done to prove or disprove the question at hand. Fortunately for humankind, the above-mentioned investigators had the insight and fortitude to carry out their necessary experiments.

Chairman
Human Experimentation Committee
Berkeley, Gloucestershire

February 10, 1796

Dear Sir:

You have no doubt noticed that smallpox has been and remains a constant threat to the well-being of this

country's, nay, the world's population. I would request your permission to study a theoretical method, the details of which I describe below, of preventing this dread malady.

I am told by the folk in my county that those calling themselves milkmaids are resistant to the horrors of smallpox. Cattle are known to harbor cowpox from which they suffer little. Perhaps milkmaids acquire cowpox and thus acquire their subsequent resistance to smallpox by whatever means I am not sure. Supporting this thesis is the fact that those surviving smallpox are not known to redevelop the disease regardless of future exposure.

I wish to procure a number, say 20, of children who have not previously had smallpox. I would then place a small portion of the purulent material from a fresh sore of a milkmaid suffering from cowpox into a fresh cut on each child. Subsequently, I would observe the number of children who observe smallpox and the severity of each case. I remain

Your humble servant,
Edward Jenner

Doctor Edward Jenner
Physician
Berkeley, Gloucestershire

March 20, 1796

My dearest Doctor Jenner:

The Human Experimentation Committee has met concerning your request dated February 10, 1796 and the Chairman has requested I write their report to you.

Due to many reasons, your request has been denied. We do not expect that revision of your plans could alter this Committee's final decision. Some comments generated by this Committee include:

1. Surely, as a physician, you would not base any experimentation on the hearsay of some milkmaids.
2. We doubt that a disease native to cattle could be transmitted to humans and vice versa.
3. A more likely explanation for the decreased incidence of smallpox in milkmaids would center around the fact that they spend more time with cattle than humans and therefore are at less risk.
4. This Committee is unalterably opposed to experimentation involving children with or without their parents' consent.
5. Perhaps safer, why not see if cattle develop smallpox following exposure to infected children.
6. Because of the smell of purulent material, we would require that the material expressed from the milk-

maids fresh sores be boiled at least one hour before placement into the lesions of the children.

Regretfully,
Secretary for the Chairman

Chairman
Human Experimentation Committee
Berkeley, Gloucestershire

March 31, 1796

Dear Committee:

Thank you for your letter of March 20, 1796 which I have just received and read with disbelief. I regret to inform you that I was so confident that the Committee would see fit to grant me permission to undertake the study that I have already begun preliminary observations.

Just a fortnight ago, an opportunity arose. A lad of 8, named James Phipps, came to my clinic. Otherwise healthy, he had two small scratches on his arm. Earlier that day in my practice, a milkmaid, Sarah Nelmes, consulted me regarding cowpox. On seeing the lad, I summoned Miss Nelmes and placed some fresh purulent matter from one of sores into the wounds of the young man.

I am sorry for this error. It will not happen again. To date he has developed no signs or symptoms of smallpox but has developed what is referred to as cowpox, or at least by my diagnosis.

Humbly yours,
Edward Jenner

Dr. Edward Jenner
Physician
Berkeley, Gloucestershire

April 8, 1796

Dear Doctor Jenner:

The Committee cannot overstate its disapproval of your recent action regarding the Phipps lad. You have acted totally without regard to and in direct violation of our recommendations. Your therapeutic attempts are without merit and are to be abhorred. You have allowed lay heresay regarding a few chance phenomena to bring your otherwise sound London training to its knees. What will your mentor John Hunter think of his student? You will cease and desist such actions. Understandably, you

are liable for any illness or misfortunes which befall Master Phipps.

For the Committee
Secretary

Doctor Edward Jenner
Physician
Berkeley, Gloucestershire

July 30, 1796

Dear Doctor Jenner:

You are most correct in stating you have acted upon your own. This Committee has nothing and will have nothing to do with your profession now or in the future. We have relayed this matter to the Ethics Committee of the Medical Society and have requested the cessation of your license to practice. You have obviously taken leave of your senses and must be prevented from future medical practice in order to protect humankind.

For the Committee
Secretary

Chairman
Human Experimentation Committee
Berkeley, Gloucestershire

July 15, 1796

Dear Sirs:

It may please you to note that I have not continued my studies on any other children. However, having already incurred your wrath concerning the Phipps lad, I have made one more observation. After his cowpox sores had subsided, I placed fresh matter from the sores of a routine case of fatal smallpox into new scratches made in the forearm of the Phipps lad. In the following 2 months, he has not developed any signs or symptoms of smallpox. I recognize I have made these studies on my own.

Your servant,
Edward Jenner

Craig S. Kitchens, M.D.
Gainesville



Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/Roche)® , please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug.
Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.
Adults: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Branchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications: Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings: Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, i.v. steroids, airway management, including intubation, should also be administered as indicated.

Precautions: Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions: Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure: Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

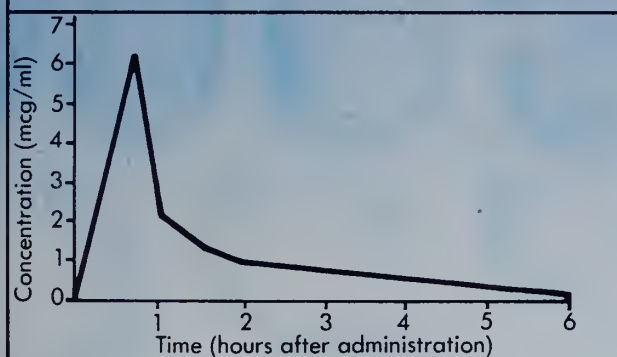
†depending on severity

Wyeth Laboratories
Philadelphia, Pa 19101

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on $T^{1/2}$ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Wyeth Laboratories • Philadelphia, Pa 19101



Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

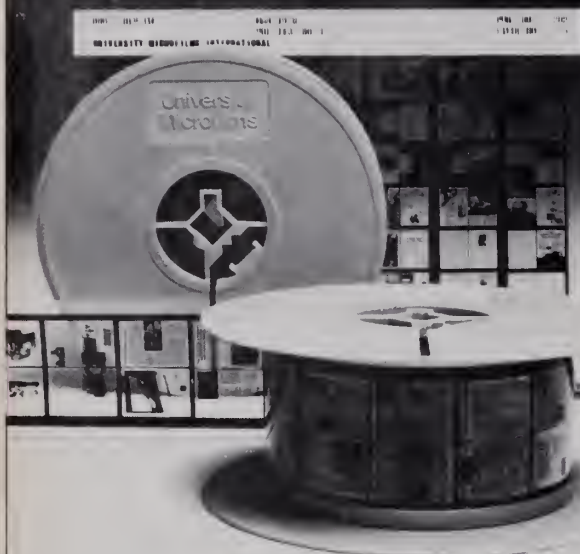
See important information on facing page.

CYCLAPEN®-W
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW
NAME

This publication
is available in microform.



University Microfilms International

Please send additional information
for _____

Name _____ (name of publication)

Institution _____

Street _____

City _____

State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

PROFIT FROM OUR EXPERIENCE

For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

We specialize in attaining the results that you require from your account in the areas of:

● **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.

● **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.

● **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

PEOPLE WHO KNOW HOW.

**Florida National
Trust Services**

214 Hogan Street
Jacksonville, Florida 32231
Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC

GIARDIASIS.

NOW THERE IS A BETTER METHOD OF DIAGNOSIS WHEN STOOL EXAMS ARE NEGATIVE.

ENTERO-TEST® A 140cm nylon line coiled inside of a gelatin capsule designed to retrieve duodenal contents without intubation. Easily administered and tolerated. ENTERO-TEST® has the following advantages:

- A viable alternative to intubation
- Well tolerated by all age groups
- Pediatric sizes available
- Useful in the diagnosis of bleeding and a variety of intestinal parasites

Rosenthal and Leibman studied 23 pediatric patients with diarrhea. All had one or more negative stools. Of these, 5 patients had *Giardia lamblia*

which was diagnosed by the simple ENTERO-TEST® procedure. Lopez and co-workers diagnosed Giardiasis in 22 patients with the ENTERO-TEST® compared to 4 patients by stool exams. ENTERO-TEST® has proved to be a useful and effective method for the localization of upper GI bleeding, and the diagnosis of Typhoid carriers, strongyloidiasis and other parasitic diseases.

References:

Rosenthal, P., and Liebman, W.M: Comparative study of stool examinations, duodenal aspiration, and pediatric Entero-Test for giardiasis in children. *J. PEDIAT.* 96: 278 (Feb.) 1980.

Thomas, G. E., et al: Use of the Entero-Test duodenal capsule in the diagnosis of giardiasis. *South Afr. Med J.* 48: 2219, 1974.

Lopez, M. E., et al: Infeccion duodeno-yeunal en el niño con desnutricion energetico-proteinica. *Rev. Med. Hosp. Nat. Niños* 13: 53, 1978.

Gilman, R. H: Identification of gall typhoid carriers by a string bladder device. *The Lancet*: April 14, p. 795, 1979.



(800) 227-8162
2551 Casey Ave.
Mountain View
California 94041

ENTERO-TEST®, The Solution. Simple And Convenient.

EXOTIC SUMMERTIME FRUIT

The FLORIDA MANGO has long been known as the finest fruit of the Tropics. It is rich, delicious, and has a tempting fragrance. (Available 6/14-7/27)

The FLORIDA AVOCADO is truly a rare fruit, with a unique flavor. Great with dressing, and of course, fabulous in dips. (7/10-7/27)

FLORIDA PERSIAN LIMES are long-time tropical treats. Make excellent thirst quenching drinks, and the best lime pies. Juicy! (7/14-7/27)

TROPICAL LUAU — the best of all worlds. A variety assortment of Mangos, Avocados, Persian Limes, COCONUTS, and a box of Tropical Candy. (Total weight approximately 25 pounds). Mangos substituted for Avocados before July 10th. (6/24-7/27).

Florida's Golden Summer VALENCIA ORANGES. Great for juice, hand-eating, salads or fruit cups. Tree-ripened and picked fresh for your order (7/14-7/27).

All Mangos, All Avocados, or special mix of half each fruit:

½ Lug	— Approximately 8 lbs.	\$12.95
Full Lug	— Approximately 16 lbs.	\$17.95
½ Bushel	— Approximately 28 lbs.	\$26.50

Valencia Oranges:

1 Bushel	\$29.50
¾ Bushel	\$25.50
½ Bushel	\$19.95

Persian Limes:

¼ Bushel	\$13.95
½ Bushel	\$20.95

Tropical Luau: \$23.50

All prices include delivery. Please state fruit desired and size.

Please have orders in the mail by July 14, 1981.

Brochures may be obtained from your local Chairman or President, or

Florida Medical Association Auxiliary
Mrs. David S. Whittaker
1140 S.E. Fort King
Ocala, Florida 32670

Make checks payable to "FMA-Auxiliary-FMF" and remember, all benefits go to the Florida Medical Foundation:

NAME _____

ADDRESS _____

PHONE NUMBER _____

When you need a lot of money, DAC and your house may be the best friends you have.



As a physician, cash flow and large dollar requirements can sometimes be a problem. Probably one of your biggest assets and surest means of obtaining large cash sums is your home equity.

Let DAC show you how simple it can be to arrange a home equity loan. Loans are available for up to \$50,000 or more with terms up to 12 years.

So, if you need cash for setting up or expanding a practice, new equipment, business investments, major purchases, etc., call your nearest DAC office — there are 13 in Florida!

Licensed Mortgage Broker

DAC
Corp. of Fla.

An affiliate of The Old Stone Bank

Professionals Helping Professionals For Over 20 Years

Bradenton
6221 14th St. West
756-9575

Clearwater
2280 U.S. Highway 19 N.
796-2587

Daytona Beach
2040 S. Ridgewood Ave.
761-8500

Ft. Lauderdale
1771 N. W. 40th Ave.
735-5111

Jacksonville
3986 Boulevard Center Dr.
396-9496

Lakeland
402 S. Kentucky Ave.
687-2533

Melbourne
17 E. Hibiscus Blvd.
727-3510

Ocala
2945 N. E. 3rd St.
732-4336

Orlando
3438 Lawton Rd.
894-3711

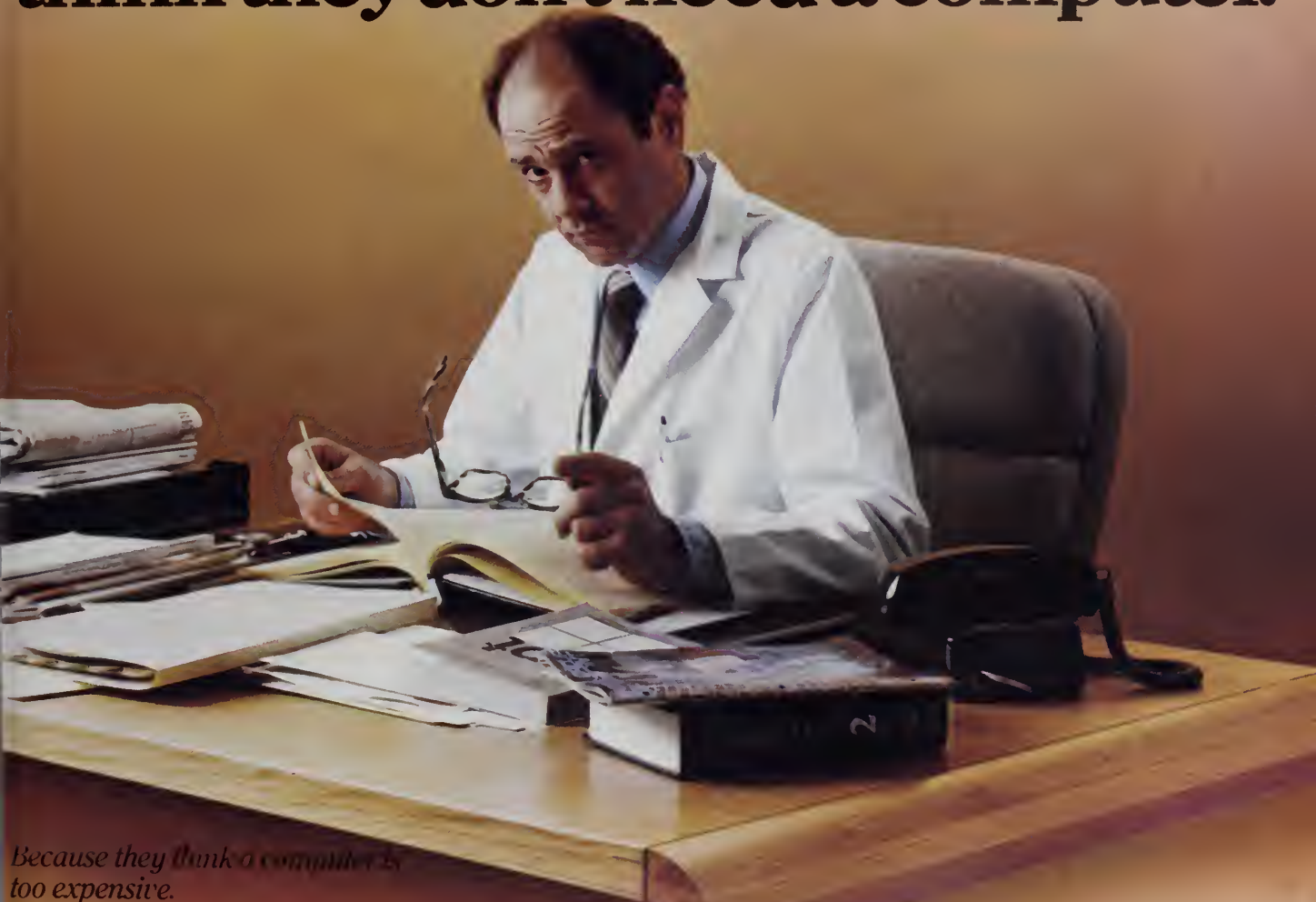
Pensacola
5150 Bayou Blvd.
478-3215

Tallahassee
2574 Seagate Dr.
878-3149

Tampa
402 Reo St.
879-3181

West Palm Beach 2240 Palm Beach Lakes Rd. 689-0080

We're looking for doctors who think they don't need a computer.



Because they think a computer is too expensive.

The Sequoia Medical System™ can pay for itself:

- Increased collections
- Decreased receivables
- Improved staff efficiency

Because they think they already have firm control of their billing.

The Sequoia Medical System automatically processes billing paperwork:

- Patient statements
- Third party claims
- Collection letters

Because they think they have easy access to vital practice data.

The Sequoia Medical System provides information immediately:

- Aged receivable reports
- Procedure and diagnosis analysis

- Daily production and revenue analysis
- On-line access to 4½ million medical journal articles in the National Library of Medicine
- And many other forms of essential data

Because they think a computer is administratively disruptive.

The Sequoia Medical System is designed to blend smoothly into solo and small group practices:

- Easy to use
- Pre-programmed, turn-key system

- Includes training, installation, local service and support.

Because they haven't seen a Sequoia Medical System.

Sequoia can provide more time for health care in your practice. While it's taking care of business... you're taking care of patients.

Start looking into the benefits of a computer today by calling Sequoia Group. Call toll free (800) 227-2360; in California (800) 772-2655 ... or write for our brochure.

SEQUOIA GROUP™
I N C O R P O R A T E D

1100 Larkspur Landing Circle, Larkspur, CA 94939

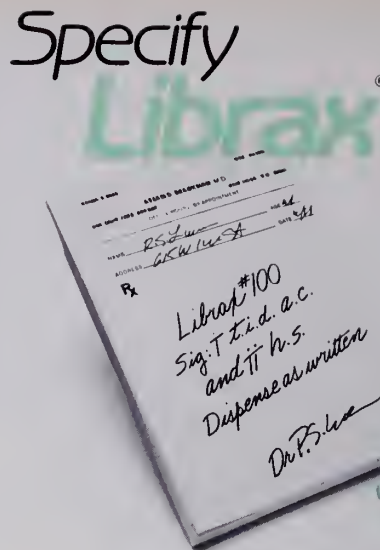
Atlanta, Birmingham, Boston, Buffalo, Charlotte, Chicago, Cleveland, Columbus, Dallas, Denver, Detroit, Hartford, Houston, Indianapolis, Irvine, Kansas City, Los Angeles, Memphis, Miami, Minneapolis, Nashville, New Orleans, New York City, Norfolk, Oklahoma City, Philadelphia, Phoenix, Pittsburgh, Portland, Salt Lake City, San Diego, San Francisco, Seattle, St. Louis, Tampa, Washington, D.C.

Ready
to teach
home
nursing,
first aid,
parenting,
child care,
water
safety,
CPR.

Red Cross:
Ready for a new century.



A Public Service of This Magazine
& The Advertising Council



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows "Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets



Roche Products Inc
Manati, Puerto Rico 00701

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

MAY 1981
VOL 68 • NO. 5

Experience With Tc 99m HIDA in the Diagnosis of Acute Gallbladder Disease in Columbia County, Florida

Ricardo Bedoya, M.D.

Abstract: The available reports relating to Tc 99m HIDA (N-2, 6-Dimethylphenylcarbamoymethyl) Iminodiacetic Acid) and HIDA-like compounds in the diagnosis of acute gallbladder disease have until now evolved from teaching institutions or other major medical centers. This paper summarizes 1½ years experience in a medical community serving a population of approximately 40,000. The number of our cases is consequently limited. Our results, however, support the usefulness of and indicate the high degree of diagnostic accuracy obtained with this new diagnostic modality.

Radiologic assessment of the status of the gallbladder and bile ducts by means of oral cholecystogram or intravenous cholangiography is with some frequency not diagnostic in the presence of acute cholecystitis.¹ In the acutely ill patient oral cholecystography may be too time consuming while intravenous cholangiography is of limited value.^{1 3 7} Non-visualization of the gallbladder by either of these two contrast procedures is not specific for acute cholecystitis and does not necessarily mean that the cystic duct is obstructed by the pathologic process.^{1 8} Acute cholecystitis is associated with cystic duct obstruction in the vast majority of cases.^{1 3 6 8} Therefore, the key diagnostic question in the acute clinical setting is whether or not the cystic duct is patent. Diagnostic accuracy has improved from the early development of non-invasive modalities such as standard radiographic examinations to the more recent introduction of ultrasound, computed tomography and radionuclide techniques.

The Author

RICARDO BEDOYA, M.D.

Dr. Bedoya is a radiologist practicing at Lake Shore Hospital in Lake City.

Cholescintigraphy has proven to be the most sensitive method available for documenting cystic duct patency or obstruction, and has become the diagnostic procedure of choice for acute cholecystitis.^{4 6 9}

The development of cholescintigraphy required the finding of compounds that were taken up specifically by the liver and excreted into bile. N-(2, 6-dimethylphenylcarbamoymethyl) iminodiacetic acid (HIDA) is an N-substituted iminodiacetic acid structurally related to the drug lidocaine. The iminodiacetic acid moiety is a metal-chelating group, which allows the analog molecule to be radiolabeled with technetium 99m.^{2 5} HIDA is produced easily by instant kit in a form that can be radiolabeled with technetium 99m. The resultant radiopharmaceutical has high radiochemical purity, and is stable both in vitro and in vivo.²

Previously reported results with the new agents in the diagnosis of acute gallbladder disease have been encouraging.^{1 3 7} Because of these results, we obtained a license for the use of Tc 99m HIDA in Phase III of the investigation of this new diagnostic pharmaceutical.

The technique is characterized by being safe, fast, simple and non-invasive. We expect that our results will stimulate further interest in the use of this compound in

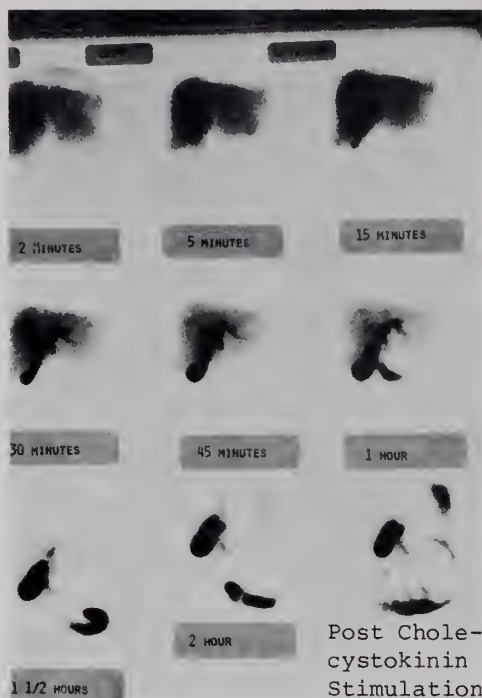


Fig. 1. — White female, age 65. Normal gallbladder in patient seen in Emergency Room with suspected acute cholecystitis. The gallbladder begins to visualize in the 15 minute scan showing progressive accumulation of Tc 99m HIDA in subsequent scans. This type of filling with relative increase in size of gallbladder has been in this study a reliable indication of normal gallbladder.

the diagnosis of acute gallbladder disease, as a conclusion is frequently reached early in the course of the disease. HIDA and ultrasound have proven to be of invaluable help in either establishing the suspected diagnosis of acute gallbladder disease or excluding same. This helps the referring physician to orient his workup toward other diagnostic possibilities when indicated.

Methods:

An average dose of 7 millicuries of Tc 99m HIDA was administered intravenously to each of our patients. A series of scintigrams was obtained at 1, 5, 15, 30, 45, 60 and 90 minutes. On a few occasions delayed scans at 2 and 2½ hours after injection were done.

With three exceptions, the bilirubin levels of our patients were within normal limits. The studies were obtained with a Searle PhoGamma 5 camera. Patients fasted for at least two hours prior to the test. Despite the excellent HIDA results reported by other investigators, we also used, when possible, other diagnostic modalities such as ultrasound and oral cholecystograms to confirm impressions obtained from HIDA scans. Only in a few instances were we unable to do so because of medical indications for immediate surgical intervention.



Fig. 2. — Representative example of non-visualized gallbladder in a patient with proven cholecystitis with associated cholelithiasis. Note normal common duct.

Summary of Results:

In 27 of the 45 cases having a clinical diagnosis of possible acute gallbladder disease, the gallbladder was not visualized. In 24 of these patients, the diagnosis of acute cholecystitis was proven histopathologically. (Fig. 2 and 3). Cholelithiasis was present in the majority of them, but in one of these patients chronic cholecystitis without calculus was found.

In two of these patients with non-visualized gallbladders, abnormal hepatic function with significant impairment in the excretion of the pharmacological compound by the liver was noted. In these two patients in which the gallbladder was not visualized and who did not have primary gallbladder disease, ultrasound was of great help in demonstrating normal gallbladders thereby preventing false-positive findings.

In 18 of the 45 cases the gallbladder was visualized. In two of these cases, however, the gallbladder was proven to be abnormal and gallstones were demonstrated in both instances. (Fig. 4 and 5)

Comments on Results:

In normal patients, Tc 99m HIDA is promptly cleared and excreted by the hepatocytes into the biliary system with progressive accumulation of radiopharmaceutical in the gallbladder. This progressive accumulation with increase in size of gallbladder has been, in our experience, a reliable indication that the gallbladder is normal. (Fig. 1)

In two instances in which the gallbladder was visualized in spite of containing gallstones, and the histopatho-

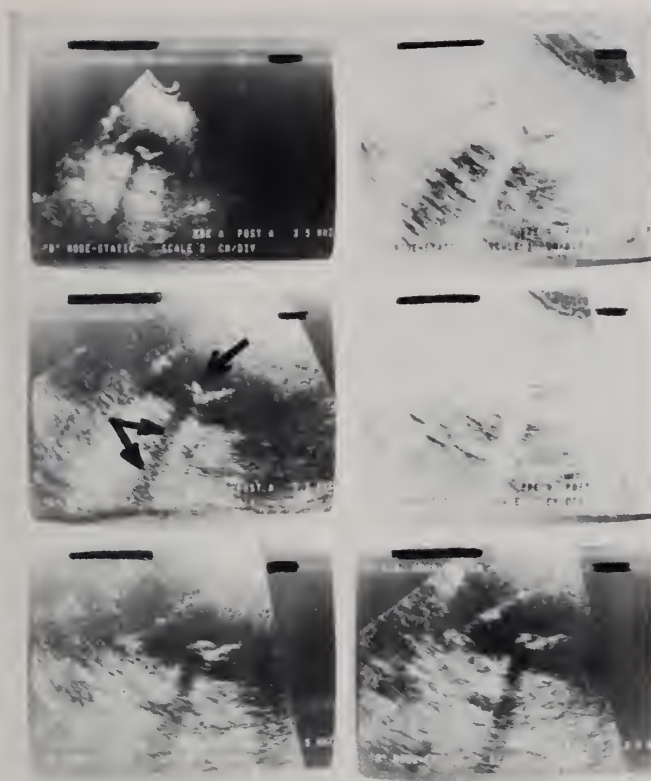


Fig. 3.—Gallbladder sonogram on the same patient including magnification views reveals gallstones with distant casting shadows. There is also thickening of gallbladder wall. Single arrow — stone. Two arrows — casting shadow.

logical findings of chronic cholecystitis with patent cystic duct were demonstrated, rapidity of the filling of the gallbladder was abnormal. There was in fact delay in visualization of the gallbladder without the significant progressive accumulation of compound which was noted in the patients with normal gallbladders. With the exception of the two patients with abnormal hepatic function, all the patients in which the gallbladder was not visualized were proven to have inflammatory gallbladder disease.

Significant impairment of hepatic function results in slow excretion of the radiopharmaceutical which prevents satisfactory accumulation of this compound in the gallbladder. When this situation is suspected, tests of hepatic function can help to clarify the problem. We have, however, one patient with a 3.2 milligram total bilirubin in which the gallbladder was not visualized in the oral cholecystogram, but was demonstrated with Tc 99m HIDA. There is no doubt that in the presence of slight to moderate elevation of bilirubin levels the chances of visualizing the gallbladder are higher with HIDA than

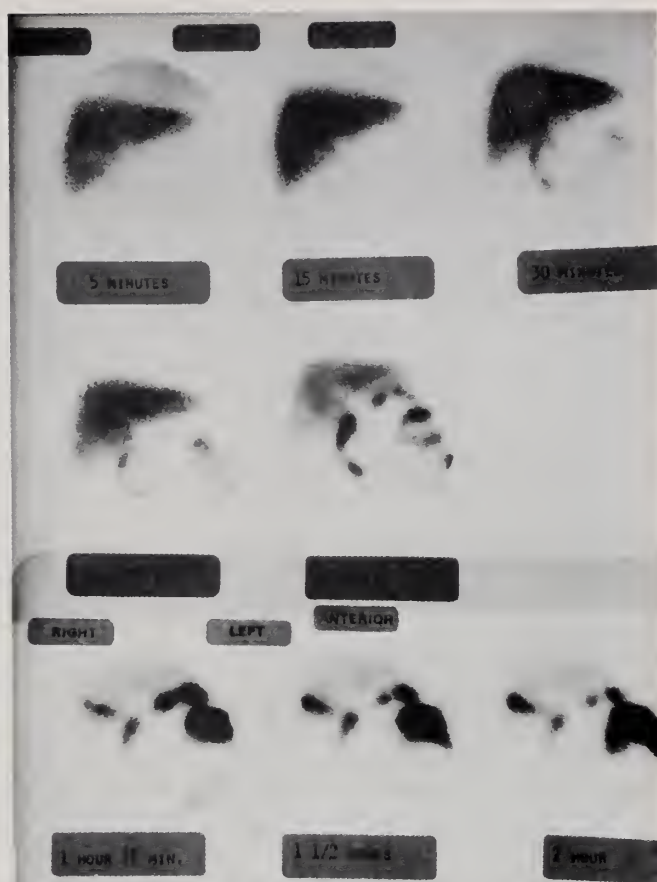


Fig. 4.—White male, age 45. Example of cholecystitis with features of chronic and acute process with patent cystic duct. The sequence of filling of gallbladder is abnormal. Note "cold" gallbladder fossa in the scans obtained during the 1st hour after injection of the radiopharmaceutical. There is delay in the visualization of the small gallbladder. This diseased gallbladder fails to show significant progressive accumulation of Tc 99m HIDA in the delayed scans.



Fig. 5.—White male, age 45. Oral cholecystogram obtained the following day of same patient. See Fig. 4. There is impairment of concentrating ability of gallbladder and visualization of multiple radiolucent calculi.

with oral cholecystograms.

In reference to the sequence of events in the scanning of the liver and gallbladder in patients with normal hepatic function, we have noticed that when the gallbladder is not visualized in the scans obtained within 90 minutes following the injection, a normal gallbladder will not be visualized in further delayed scintigrams.

We found HIDA also to be very helpful in those patients having problems with absorption of oral contrast material. In three different instances in which oral contrast material was not absorbed by the intestinal tract, we were able to demonstrate normal gallbladders after the intravenous injection of HIDA. The not infrequent situations of patients with either intestinal absorption problems or intolerance to orally administered medication, would be among the indications for using HIDA.

One of the patients included in this study was referred with a definite history of previous allergy to oral cholecystogram contrast material. In this patient, with the help of HIDA, we were also able to demonstrate a patent cystic duct and normal sized gallbladder.

Conclusions:

Our results support the usefulness of Tc 99m HIDA in the diagnosis of acute cholecystitis. Visualization of the gallbladder with progressive accumulation of the radiopharmaceutical within two hours as demonstrated in Fig. #1 should be considered reliable evidence of a normal gallbladder.

Non-visualization of the gallbladder with Tc 99m HIDA should be interpreted as reliable supportive evidence of a clinical impression of acute gallbladder disease. (Fig. 2) Other clinical situations to be excluded in the case of a non-visualized gallbladder are acute pancreatitis with concomitant hepatobiliary dysfunction, hepatic insufficiency, previous cholecystectomy and the relatively rare occurrence of congenital absence of the gallbladder.⁸

Filling of a subnormally sized gallbladder which fails to progressively distend should alert the physician to the possibility of chronic cholecystitis with patent cystic duct. (Fig. 4) Some of the false-negative results with Tc 99m HIDA recently reported in the medical literature may be related to this situation.⁴ Demonstration of the gallbladder by HIDA scan alone does not necessarily exclude gallbladder disease. Timing and completeness of filling are the important factors to be considered.

The results reported in this paper support the concept that oral cholecystograms, gallbladder scintigraphy and ultrasound are not, and should not be considered competitive diagnostic modalities. On many occasions, these studies complement each other. As yet, oral cho-

lecystograms have no substitute as an excellent function test. Neither gallbladder sonogram nor HIDA studies can evaluate concentrating ability of the gallbladder mucosa. Ultrasound and Tc 99m HIDA are valuable diagnostic tools in the acutely ill patient, especially when an early diagnosis is needed.

The outstanding capabilities of ultrasound in detecting calculi are noteworthy. However, depending on the location of the stones at the time of the study, quality of sonograms, and experience of the sonographer, the stones may be missed during the crucial acute episode of cholecystitis with cholelithiasis. Although cholescintigrams do not have the resolution capabilities to detect the presence of stones, indirect evidence of the presence of a calculus in the cystic duct may be obtained by non-visualization of gallbladder in a patient suspected of having acute cholecystitis.

In patients with acalculus cholecystitis nonvisualization of the gallbladder with HIDA is due to functional obstruction⁹ produced by viscid bile, together with the inflammatory reaction in the cystic duct.

The clinician should be aware of all these possible situations so that he can cooperate with the radiologist in attaining the final objective of establishing an accurate diagnosis.

Acknowledgement

I would like to express my appreciation to my partner, Henry E. Plenge, M.D. and to Alberto Gonzalez, M.D. for their cooperation in the interpretation of some of the scans reported in this study. I am also deeply grateful to all others contributing to the completion of this paper, particularly Mrs. Melba Reynolds for her patient assistance in the recording of the many facts and in the typing of this article.

References

1. Pare, P.; Shaffer, E.A.; Rosenthal, L.: Nonvisualization of the Gallbladder by 99m Tc-HIDA Cholescintigraphy as Evidence of Cholecystitis. *CMA Journal* 118:384, February 18, 1978.
2. Ryan, J.; Cooper, M.; Loberg, M.; Harvey, E. and Sikorski, S.: Technetium-99m-Labelled N-2, 6-Dimethylphenylcarbamoylmethyl Iminodiacetic Acid (Tc 99m HIDA): A new Radiopharmaceutical for Hepatobiliary Imaging Studies. *J. Nucl. Med.* 18:995-1002, 1977.
3. Rosenthal, L.; Shaffer, E.A.; Lisbona, R. and Pare, P.: Diagnosis of Hepatobiliary Disease by 99m Tc-HIDA Cholescintigraphy. *Radiology*, Vol. 126, #2, p. 467-474, February 1978.
4. Echevarria, R.A. and Gleason, J. L.: False-Negative Gallbladder Scintigram in Acute Cholecystitis. *J. Nucl. Med.* 21:841-843, 1980.
5. Loberg, M.D.; Cooper, M.; Harvey, E.; Callery, P. and Faith, W.: Development of New Radiopharmaceuticals based on N-substitution of Iminodiacetic Acid. *J. Nucl. Med.* 17:633-638, 1976.
6. Caretta, R.: Hepatobiliary Imaging with Iminido Compounds. *Diagnostic Imaging*, May 1980. p. 4.
7. Ravin, T.H. and Verdon, T.A. Jr.: What is the Role of Gallbladder Ultrasound and HIDA Studies Today? (an editorial) *Applied Radiology/Ultrasound* 8:142, Nov.-Dec. 1979.
8. Okuda, K. and Masahiro, I.: Radiological Aspects of the Liver and Biliary Tract, X-ray and Radioisotope Diagnosis. Chicago: Year Book Publishers, Inc., 1st edition, 1976.
9. Weissman, H.S., et al. Spectrum of 99m-Tc-HIDA Cholescintigraphic Patterns in Acute Cholecystitis. *Radiology* 138:167-175, January 1981.

● Dr. Bedoya, P.O. Box 1989, Lake City 32055.

Florida Statewide Cancer Data System

James T. Howell, M.D., M.P.H., R. Michael Yeller, M.D., and Douglas G. Palin, M.S.

Abstract: The Florida Statewide Cancer Registry Program, established under Section 381.3812, Florida Statutes, is discussed and the roles and responsibilities of the Department of Health and Rehabilitative Services, hospitals, and Florida Cancer Data System are described. The article presents information regarding the value of a population-based, follow-up cancer registry, background on the program and its relationship to the Cancer Control and Research Act, training and assistance available to hospitals for reporting cancer patients, and the schedule for full implementation of the program.

The Florida Public Health mission for cancer is to support the ability to delineate problems by specifically identifying resources and data required.

Since the 1950's, cures of primary and metastatic disease have importantly changed the logic of cancer management. The list of cancers and metastases curable by chemotherapy, radiation or combination therapy is increasing. Furthermore, even greater successes are being achieved with childhood cancer. DNA synthesis, immunologic studies, improving technology in radiation therapy and improved surgical techniques, pathology and pathophysiology have provided the oncologist with a wealth of new information. The study of these variables can be judged by the current state of the art in Florida.

Cancer Problem in Florida

In 1978, 21,639 deaths, or 22.7% of all deaths in Florida, were caused by cancer compared to 17.4% ten years earlier. Florida, with an unadjusted rate of 241.3 per 100,000 population,¹ has the highest death rate for cancer in the nation. The national cancer death rate for that year, as reported by the National Center for Health

Statistics (NCHS), was 181.9 per 100,000 population.² Based on death statistics, the American Cancer Society (ACS) estimates that in 1980 there will be 44,000 new cases of cancer in Florida.³ However, the accuracy of this projection may be challenged due to the lack of actual data on incidence and prevalence of the disease.

The 1978 rates for Florida and the nation were 241.3 and 181.9 per 100,000 respectively, while the age adjusted rates were 132.1 and 133.8.^{4,5} The reversal of relative positions is caused by the age structure of the Florida population which has a much greater proportion of people over 64 than the national average. This does not necessarily mean, however, that this older group has a higher rate of cancer deaths. On the contrary, it appears that the phenomenon is caused by the total number of deaths, not by the frequency with which these deaths occur. Table 1 confirms this, indicating that Florida's age specific rates are lower for residents under 25 and between 65 and 84. However, residents between 25 and 64 suffer a higher rate than the national average.

The data illustrate that, while the large number of over 65 retirees may enjoy a lower cancer death rate, a problem of excess mortality exists among the productive aged population of the state. The only way to define and address this problem in a meaningful way is with timely, reliable data. The best way to obtain such information is with the statewide cancer registry.

Cancer Control and Research Advisory Board

The Cancer Control and Research Act of 1979 created the 25-member Cancer Control and Research Advisory Board. The Board, composed of professionals in the field of cancer, public figures and the general public, is called upon to approve "a plan for the care and treatment of persons suffering from cancer." The Board is further enjoined to "recommend the establishment of standard requirements for the organization, equipment

The Authors

JAMES T. HOWELL, M.D., M.P.H.

Dr. Howell is staff Director of the Health Program Office and State Health Officer, Tallahassee.

R. MICHAEL YELLER, M.D.

Dr. Yeller is Medical Program Administrator, Disease Control, Health Program Office.

DOUGLAS G. PALIN, M.S.

Mr. Palin is Cancer Program Manager with the Department of Health and Rehabilitative Services, Health Program Office.

**Table 1. — Age Specific Death Rates for Florida and U.S.
August 1976-1978**

Age	Place Florida	U.S.	Ratio Florida/U.S.	Standard Error of Ratios
1	2.2	3.7	.59	.44
1-4	4.3	5.1	.84	.22
5-14	3.8	4.7	.81	.13
15-24	6.1	6.4	.95	.12
25-34	16.1	14.4	1.12	.10
35-44	55.3	50.7	1.09	.06
45-54	197.8	183.0	1.08	.03
55-64	442.9	440.2	1.01	.02
65-74	719.3	793.2	.91	.01
75-84	1122.1	1270.0	.88	.01
85+	1578.2	1445.9	1.09	.03
Total	233.8	178.7	1.31	.01

Sources: Florida Vital Statistics
Monthly Vital Statistics Report, DHHS

and conduct of cancer units or departments in hospitals and clinics in Florida".⁸

In order to develop such a plan in a responsible manner, researchers, physicians, planners, public health officials and other health professionals need reliable data on cancer incidence, mortality and treatment. Anticipating this need, the Florida Legislature created the statewide cancer registry program in 1978. Section 381.3812, F.S., requires all licensed hospitals to report to the Department of Health and Rehabilitative Services (HRS) every patient admitted for treatment of cancer.

Florida Cancer Data System

In 1979 funds were appropriated by the legislature to conduct a pilot project involving six hospitals with tumor registries and to establish the Florida Statewide Cancer Registry to receive, store and analyze reports submitted by hospitals in compliance with the reporting requirements. The Comprehensive Cancer Center for the state of Florida at the University of Miami was contracted to develop and operate the Florida Cancer Data System (FCDS). In addition to funding administration of the project, the law requires that 65% of all funds appropriated be used to reimburse the hospitals to help defray the costs involved in case finding, abstracting and coding the cancer cases for submittal to HRS.

Between January and June of 1980, nearly 3,000 cases were reported from these six hospitals. This pro-

vided the material necessary for the development and testing of the FCDS in preparation for statewide implementation during FY 1980-81.

Hospitals have three alternatives as to the manner in which they report cancer. They may use the Confidential Identification Report (CIR) form (Fig. 1) which provides basic information such as case identification, basic demographic information, site of tumor, date of diagnosis, and whether the patient was treated or referred. This form notifies FCDS that the case has been admitted, so that field staff can go to the hospital to abstract the case. It will also provide immediate information for incidence data.

The second alternative, and the manner encouraged by HRS, is for the hospital to report to FCDS on the Confidential Report of Malignancy (CRM) form (Fig. 2) without coding the data on the coding strip. Coding will be done by FCDS.

The third alternative is for the hospital to complete the CRM and code the data.

The hospital is reimbursed on the basis of the alternative chosen: identification on a CIR \$1.50 per case, acceptable uncoded CRM's \$10.50 per case, and encoded CRM's \$15.00.

An implementation schedule has been set for statewide reporting by all hospitals. Most hospital registries began reporting before the end of 1980. Other hospitals with over 300 beds began January 1, 1981, all hospitals in HRS Districts 5, 6 and 8 (southeastern Florida) began April 1, 1981, and all other hospitals in the state June 30, 1981. Regardless of the date the hospital begins to report, every cancer patient admitted after January 1, 1981 is to be reported. Hospitals reporting on the CRM should abstract cases four weeks after patients are admitted to ensure availability of all necessary documentation. Those using the CIR form should report as soon as cancer is diagnosed.

Fig. 1

Hospital administrators and tumor registrars have been informed of their responsibilities under the law and of procedures to be followed in reporting and in invoicing HRS for reimbursement. Administrators and medical records staffs of hospitals without established tumor programs have been provided information regarding case finding, abstracting, coding, and administrative requirements.

Legislation, requiring hospitals to report cancer, mandates establishment of a statewide cancer registry program. A cancer registry is defined as "a data handling system which identifies and follows the course of the cancer patient's illness from the onset of symptoms through outcome".⁹

The Florida Cancer Data System is compatible with hospital registries approved by the American College of Surgeons' Commission on Cancer, Federal Surveillance, Epidemiology and End Results (SEER) program and Centralized Cancer Patient Data System (CCPDS). FCDS is "a population based registry collecting data on all cancer patients who are residents of a particular area [Florida]." "Population based registries are interested in information on trends in the occurrence of various forms of cancer, in changes in diagnostic and treatment practices and their associated 'end results', and in epidemiology of cancer."¹⁰ Data reported to FCDS include

patient identification, demographic variables, diagnosis/morphology, stage of disease, metastatic disease, treatment, disease status, pathology and quality of survival. By computer analysis, FCDS will provide an annual unduplicated count of patients and new cancer cases.

In order to provide information on diagnostic and treatment practices and end results, every effort will be made to facilitate the systematic follow-up of patients at regular intervals. Such follow-up will help save lives by early detection and treatment of local and regional recurrence, as well as distant metastases and second primary lesions.

The Department is charged by the registry law to "use or publish said material only for the purpose of advancing medical research or medical education in the interest of reducing morbidity and mortality, except that a summary of such studies may be released for general publication".¹¹ A primary objective of the Department is to ensure timely and meaningful feedback to members of the medical profession regarding cancer in their practice, in their hospital and in Florida as a whole. Regular reports to hospitals will include individual patient information regarding site, state of disease, histologic type, date of diagnosis, follow-up status and treatment. They will be made available only to submitting hospital and physicians' names shall not be reported. These reports should

The form is a detailed medical record for cancer patients, organized into several main sections:

- DEMOGRAPHIC:** Includes fields for patient ID, operation, originating institution, accession number, sequence number, date of birth, residence (city, state, zip, county), sex, race, ethnicity, birthplace, marital status, religion, primary occupation, industry, tobacco use, and alcohol use.
- PRIOR HISTORY:** Includes fields for previous cancer diagnosis (yes/no), date, and treatment (surgery, radiation, chemotherapy, endocrine, immunotherapy, other).
- EXTENT OF DISEASE:** Includes fields for primary site, date of diagnosis, medical record number, class of case at this institution, date of diagnosis, and extent of disease (local, regional, distant, unknown).
- REFERRAL:** Includes fields for referring physician/institution, primary attending physician, and follow-up physician/institution.
- PATIENT STATUS:** Includes fields for performance status, care needs, reason for limitation, and quality of survival.
- TREATMENT SINCE ADMISSION:** Includes fields for surgery, radiation, chemotherapy, endocrine, immunotherapy, and other treatments, along with dates and status.
- OPTIONAL:** Includes fields for abstractor, verified by, and special studies.

The form is designed to be filled out by hospital administrators and tumor registrars to report cancer cases to the Florida Cancer Data System.

Fig. 2

be valuable in developing programs of professional education, identification of areas of need, and in-house review of treatment modalities.

The American College of Surgeons' liaison is Dr. Carl Brannan of Tampa. He has requested each hospital to name a physician to act as liaison between the hospital and the College of Surgeons. His/her function is to stimulate interest in developing an approved cancer program including tumor registry, cancer committee, clinical program and cancer conferences, and to provide a focus within the hospital for effective utilization by the medical and nursing staff of data produced by the system. Summary reports will provide hospitals and physicians with comparisons of the effectiveness of different treatment modalities, analysis of remission rates, and within four to five years, useful "end results", i.e., data on survival and quality of life. This will not be a sterile repository for unused and unwanted data.

Epidemiological information is needed in several areas of the planning process: (1) to identify areas of critical need for cancer care facilities and manpower, (2) to identify trends, (3) to locate "hot spots" which may indicate the existence of environmental or occupational factors in the development of the disease, (4) and to help in the identification of groups at high risk to specific forms of cancer. Epidemiological data can also provide hints as to possible etiological factors requiring further research, such as the studies being carried out by the National Cancer Institute in northeast Florida, Georgia and South Carolina "to identify the environmental and demographic factors contributing to the increased risk of lung cancer in these predominately rural and port areas".¹²

The Department and FCDS will be continually evaluating the system and the information being required to determine the value and reliability of specific items. Some data being requested may not be available in medical records and since these reports are gleaned from the patients' file, and not through patient interviews, these items must be carefully evaluated to determine whether they should be eliminated from the abstract form, or if

admission practices should be changed to ensure the gathering of the information.

Some important information may be attainable only by use of survey sampling techniques utilizing the registry to identify groups of cancer patients fulfilling specified criteria. An example is "imported cancer", i.e., patients who retired to Florida. Given present admission practices, it is seldom possible to identify the patient's original residence. Yet this is vital data to enable us to identify those patients who have lived the majority of their life in Florida and whose cancer could be related to environmental factors within the state. Such information could be obtained through a survey of a sample of the total patient population, of a given area, or a specific anatomical site.

The goal of the cancer control program in Florida is to reduce cancer morbidity and mortality, thereby reducing disability, dependency and institutionalization. The statewide cancer registry will be a keystone in planning to achieve that goal by collecting, organizing, analyzing and interpreting data obtained from the hospitals.

References

1. Florida Vital Statistics, 1978, table P, p. 13, DHRS.
2. Monthly Vital Statistics Report, DHRS, 29:30(6), 1980.
3. Cancer Facts and Figures, 1980, American Cancer Society, p. 10.
4. Florida Vital Statistics, loc. cit.
5. Monthly Vital Statistics Report, op. cit., p. 5.
6. Florida Vital Statistics, 1978, op. cit., table 24, pp. 70-71.
7. Monthly Vital Statistics Report, op. cit., table 8, pp. 28-29.
8. Section 381.3712 (4)(i), Florida Statutes.
9. New Mexico Tumor Registry: New Mexico Tumor Registry Compendium, University of New Mexico School of Medicine, Albuquerque, p. 6, as quoted in Cancer Registries and Reporting Systems in United States, Wisconsin Division of Health, Bureau of Health Statistics, June, 1977, p. vii.
10. Shambaugh, E.M. (ed): Self-Instructional Manual for Tumor Registrars, Book 1, SEER Program, National Institutes of Health, Publication No. NIH 77-917, p. 14.
11. Section 381.3812(3), Florida Statutes.
12. Mason, T. J., et al: Atlas of Cancer Mortality for U.S. Counties, 1950-1969, National Institutes of Health, p. xi.

● Mr. Palin, PDHED, 1317 Winewood Boulevard, Tallahassee, Fla. 32301.

Disseminated Coccidioidomycosis With Respiratory Failure Presenting in Florida

W. Giles Allen, M.D., Gerald N. Olsen, M.D., and Bruce M. Yergin, M.D.

Abstract: A case is described of fatal respiratory failure due to miliary *Coccidioides immitis* pneumonia which presented in Florida. Our patient with severe obstructive airway disease under treatment with corticosteroids had been in Arizona for his health on the advice of his physician. The case illustrates the hazard of this recommendation and the challenge faced by physicians practicing in areas nonendemic for this fungus.

Coccidioidomycosis is a disease woefully unfamiliar to physicians who have neither trained nor practiced in its endemic areas. With our highly mobile society, this illness cannot be considered remote to any region of the country. Unfortunately, encounters with *Coccidioides immitis* seldom result in lasting disease. To the unwary physician, these situations present nothing more than a fleeting diagnostic dilemma and to the patient an innocuous self-limiting flu-like illness. However, occasionally when infection with this highly infectious fungus goes unchecked by the host's immune defenses and unsuspected by the physician, the results can be devastating.

Case Report

The 66-year-old white man, a retired military officer, with severe emphysema was transferred to our institution during the sixth week of an illness characterized by a progressive bilateral pulmonic process which extended over the course of two separate hospitalizations.

Several weeks prior to initial presentation, he had visited Tucson,

Arizona on the advice of his physician that the climate might help his respiratory condition. He was maintained on bronchodilators and long-term prednisone therapy at a dose of 35 mg per day. During his two-week stay, he visited a tourist attraction where a horse show produced notable dust. Approximately two weeks later, at home in Florida, he experienced increased dyspnea, productive cough, fever, and an erythematous papular eruption on the palms of his hands.

On first hospitalization the travel history was not noted. He was in mild respiratory distress with a low grade fever and crackles were heard over the lower left chest. A palmar rash believed to be contact dermatitis was noted. No hepatosplenomegaly was appreciated. Laboratory data revealed WBC 11,500 and hemoglobin 14 gm %. The chest x-ray revealed a left lower lobe infiltrate not present on a routine film obtained four months earlier. *Hemophilus influenzae* was cultured from the sputum. He was given ampicillin for presumed bacterial pneumonitis and continued on bronchodilators and prednisone which was increased to 40 mg per day.

Although the pulmonary infiltrate did not clear roentgenographically over the 12-day hospital course, the fever abated, sputum production diminished, rash cleared, and he subjectively improved. He was discharged on bronchodilators and 40 mg prednisone daily.

Nine days after discharge and more than three weeks since initial symptoms, he again was admitted with fever, increased dyspnea, ankle edema, and expectoration of greenish-yellow sputum.

On examination he was in moderate respiratory distress. Blood pressure was 130/90, pulse 104, temperature 101.5 F, and respirations 28 per minute and labored. His neck was supple and auscultation of the lungs revealed scattered rhonchi. The heart rhythm was regular and no gallops nor murmurs were heard. There was no palpable hepatosplenomegaly or adenopathy. The skin appeared normal and there was no clubbing, but significant pitting edema of the ankles was present.

Laboratory data included WBC 15,000 with 90% neutrophils, no eosinophils, and hemoglobin 15 gm %. Electrolytes, alkaline phosphatase, SGOT, SGPT, albumen and quantitative serum proteins were all normal. Arterial blood gases on room air revealed PO₂ 47, PCO₂ 36, with a pH of 7.49. With 2 liters/minute nasal oxygen supplementation, the PO₂ was 72, PCO₂ 40, and pH 7.42. The chest roentgenogram (Fig. 1), revealed reticulonodular infiltrate best appreciated in the apices and midlung fields plus the previously noted left lower lobe infiltrate. Three sputum stains for acid-fast bacilli were negative, and culture again revealed *H. influenzae*. He was given ampicillin and previous

The Authors

W. GILES ALLEN, M.D.

Dr. Allen is Fellow in Pulmonary Medicine, Jacksonville Health Education Program (JHEP) at St. Vincent's Medical Center, Jacksonville.

GERALD N. OLSEN, M.D.

Dr. Olsen is Clinical Professor of Medicine, University of Florida College of Medicine (JHEP), and Medical Director of the Department of Pulmonary Medicine, St. Vincent's Medical Center.

BRUCE M. YERGIN, M.D.

Dr. Yergin is Medical Co-Director, of the Department of Pulmonary Medicine, St. Vincent's Medical Center.



Fig. 1. — Chest x-ray on second admission revealing diffuse reticulonodular infiltrates most pronounced in upper lung fields.

medications, including prednisone, were maintained. After seven days fever persisted. Due to his intermittent cloudy sensorium, a lumbar puncture was performed with normal results. Ampicillin was discontinued and erythromycin was begun empirically. Three days later his condition was rapidly worsening and he was transferred to our hospital for tissue diagnosis.

He appeared chronically ill and in moderate respiratory distress. On an FiO_2 of 0.40, arterial blood gases showed PO_2 62, PCO_2 32 and pH 7.50. Chest x-ray again showed bilateral reticulonodular infiltrates. Sputum and bone marrow stains were negative for acid-fast bacilli. The day following transfer, an open biopsy of the left upper lobe was performed, and on frozen section numerous spherules were seen in dense neutrophilic infiltration with scattered granulomas.

Postoperatively the patient was mechanically ventilated. He was begun on amphotericin B 25 mg IV with plans to incrementally increase the daily dose to 50 mg. Miconazole 2000 mg/day was also begun. Hydrocortisone 300 mg/day was administered by constant infusion.

During the second postoperative day, in spite of an increasingly higher concentration of oxygen he became hypotensive. Fever to 105.6°F was noted. A Swan-Ganz catheter was placed revealing a pulmonary capillary wedge pressure of 2 mm Hg. Despite aggressive fluid administration, dopamine and trials of continuous positive airway pressure, support failed and he expired after three days of antimicrobials.

Results of serologic examination begun preoperatively were available postmortem. Tube precipitans was positive. The complement fixation titer was 1:8.* Skin tests were not placed; results would have been of little diagnostic benefit especially in light of the long-term steroid therapy.

On postmortem examination the lungs were heavy and extensively involved with coccidioidal infection. The spleen contained spherules in focal areas of inflammation. Granulomata were absent. On microscopic examination no other organ appeared involved but *C. immitis* was grown from liver and adrenal specimens as well as from the spleen and lungs. There was no evidence of meningeal, bone, or skin involvement.

Discussion

Ironically, this patient contracted ultimately fatal coccidioidomycosis while in Arizona to improve his breathing on the advice of his physician. Furthermore, chronic steroid therapy administered to improve the emphysema undoubtedly compromised him immunologically leading to this rare presentation of respiratory failure due to *Coccidioides immitis*.

Coccidioidomycosis was first recognized over 80 years ago in devastating cases similar to the one presented. The spherules resemble the organism *Coccidia* and, therefore, early descriptions lead to the misconception that the pathogen was a protozoan, and that the disease "coccidioidal granuloma" was rare, disseminated, progressive and uniformly fatal.¹ After the organism was discovered to be a fungus, three decades passed before Dickson in 1938 convincingly demonstrated the widespread prevalence and typical benign nature of coccidioidomycosis.²

With more than 100,000 new cases each year, coccidioidomycosis contributes significantly to the overall medical morbidity within its endemic regions. Even though only 70 deaths are currently reported annually,³ the increased use of immunosuppressive therapy is making the severe forms of the disease more common.⁴

C. immitis is extremely infectious. As many as 50% of persons have positive coccidioidin skin tests within six months after being introduced into highly endemic areas of Arizona.⁵ This staggering figure could actually be a gross underestimation if the study were repeated with the more sensitive spherulin antigen.⁶ The risk of infection is dependent on the quantity of inhaled inoculum. Hence, the highest infectivity is during the late summer and early fall in the dry windy season which typically follows the rainy period of mycelial proliferation. With these conditions, merely riding through an endemic area can result in infection.⁷ Most epidemics, however, involve victims having more direct contact with dust, such as construction workers remodeling the earth's crust, arch-

*This complement fixation titer, while having significance, is not "positive."

eologists digging for relics, or children playing in dirt.⁷⁻⁹ Our patient's witnessing the tourist attraction suggests this mode of contact. On the other hand, sporadic cases result from remote exposure. Handling fomites such as cotton, wool, packaging, or even food contaminated in endemic areas, has resulted in coccidioidomycosis as far removed as Great Britain.¹⁰⁻¹² In Florida, no other deaths due to coccidioidomycosis have been reported in at least five years.¹³

Obviously, immunosuppression represents the most serious risk for development of dissemination and ultimately death. In Rowland's series of 25 cases of fatal dissemination, 52% were immunocompromised due to steroids alone or in combination with cytolytic agents.¹⁴ If underlying malignancies were included, 84% of her cases were compromised hosts. A study of all renal transplant recipients in Arizona over a six-year period showed that disseminated disease developed in 4.6% of these immunocompromised patients compared to less than 0.0007% of the general population.¹⁵ Disseminated coccidioidomycosis is becoming a more serious problem in the southwest with the increased use of immunosuppressants. Johnson's retrospective study found more deaths due to this agent in 1975 than in the previous seven years combined.⁴

There is much confusion in the literature concerning the chronicity of fatal pulmonary coccidioidomycosis. Certainly there are no clear-cut guidelines in categorically proclaiming a specific case "acute" versus "chronic". For example, in the largest series of its type, Huntington describes 45 cases of "acute fatal coccidioidal pneumonia" detailing gross and microscopic findings. He fails to report clinical data chronologically confirming acute respiratory failure.¹⁶ Certainly pathologic findings of chronic persistent coccidioidal pneumonia can be identical to some of those reported by Huntington.

Well documented cases of rapidly progressing coccidioidal pneumonia leading to respiratory failure are unusual.¹⁷⁻²² When these cases, as well as our case, are considered, several features emerge to suggest a distinctive clinical entity. The pulmonary pathology is a diffuse miliary process with inflammatory alveolar exudates coalescing with small granulomata, occasionally with a persistent primary infiltrate. In these cases the lungs were the principle target for a fulminant fungemia.²² With few exceptions, the patients are significantly compromised hosts or susceptible to dissemination due to race or pregnancy. Unless the primary disease has been determined prior to acute presentation, the diagnosis is delayed even though all reported cases have been from highly endemic areas. The time involved awaiting serologic titers often contributes to the delay before tissue diagnosis is eventually made.¹⁷

Empiric treatment with antimicrobials against tuber-

culosis or bacterial agents is generally attempted. When studied, anergy and elevated complement fixation titers are usually consistent with dissemination.

Apparently, the unusually rapid course of this entity catches even the most experienced clinicians off guard.¹⁵ Only short courses of amphotericin B are administered in most cases due to the fulminence of this presentation. Rowland could find only four cases of survivors when acute respiratory failure was due to *C. immitis*.¹⁷ Amphotericin B was given to each for extended periods of time. In addition, one received miconazole and transfer factor and another was given high doses of steroids.²³

Summary

Since coccidioidomycosis was discovered as a severe, fatal infectious, fungal disease over eight decades ago, a wealth of knowledge has been gathered. While early investigators believed *Coccidioides immitis* to be a horrendous, devastating pathogen, current information tends to reverse this concept such that today's physician rightfully considers *C. immitis* generally as a benign organism. Therein lies the danger, for even in endemic areas an air of complacency is believed to be responsible for delays in recognition of severe forms of coccidioidomycosis leading to many avoidable deaths.²³

Hopefully, this case of fatal coccidioidal pneumonia presenting in Florida will remind physicians that, in this age of jet travel, coccidioidomycosis is, in a sense, a world-wide disease. With appearance of *C. immitis* an ever-present threat, knowledge of its regions of endemicity, awareness of its infectivity, and an understanding of its opportunistic pathogenicity to susceptible populations are essential.

Acknowledgements

We would like to express our gratitude to Diane Cobb for her outstanding secretarial assistance in preparation of the manuscript and to Matthew C. Patterson, M.D., Chief, Department of Pathology, St. Vincent's Medical Center, for his postmortem examination.

References

1. Ophuls, W.: Further Observations on Pathogenic Mold Formerly Described as Protozoan, *J. Exp. Med.* 6:433, 1905
2. Dickson, C.E.: Preliminary Acute Infection with Fungus *Coccidioides*, *JAMA* 111:1362, 1938.
3. Ajello, L.: Medical Mycological Iceberg, International Symposium on Mycoses, Pan American Health Organization of World Health Organization, Washington, D.C., p. 3, 1970.
4. Johnson, W.E.: Coccidioidomycosis Mortality in Arizona, in *Coccidioidomycosis, Current Clinical and Diagnostic Status*, L. Ajello, ed., Symposia Specialists, Miami, Fla. p. 63, 1977.
5. Smith, C.E., et al: Coccidioidomycosis, in *Preventive Medicine in World War II*, Vol. 4, S.B. Hays and J.B. Coats, eds., Office of Surgeon General, Dept. of Army, Washington, D.C., p. 49, 1954.
6. Levine, H.B., et al: Dermal Sensitivity to *Coccidioides immitis*, *Am. Rev. Resp. Dis.* 107: 379, 1973.
7. Smith, C.E.: Diagnosis of Pulmonary Coccidioidal Infection, *Calif. Med.* 75:386, 1951.
8. Werner, S.B., et al: Epidemic of Coccidioidomycosis Among Archeology Students in Northern California, *N. Engl. J. Med.* 286:507, 1972.
9. Ramras, D.G.: Epidemic of Coccidioidomycosis in Pacific Beach Area of San Diego, *Am. Rev. Resp. Dis.* 101:975, 1970.
10. Symmers, W.S.C.: Cases of Coccidioidomycosis Seen in England, in *Coccidioidomycosis*, L. Ajello, ed., University of Arizona Press, Tucson, p. 301, 1967.

11. Albert, B.L., et al: Coccidioidomycosis from Fomites: Report of Case and Review of Literature, *Arch. Int. Med.* 112:253, 1963.
12. Gehlbach, S.H., et al: Coccidioidomycosis. Occupational Disease of Cotton Mill Workers, *Arch. Int. Med.* 131:254, 1973.
13. Personal Communication, Office of Vital Statistics, Department of Health and Rehabilitative Services, State of Florida, Tallahassee.
14. Rowland, V., et al: Fatal Coccidioidomycosis: Analysis of Host Factors, in Coccidioidomycosis. Current Clinical and Diagnostic Status, L. Ajello, ed., Symposia Specialists, Miami, Fla., p. 91, 1977.
15. Smithline, N., et al: Disseminated Coccidioidomycosis, in Renal Transplant Patients in Coccidioidomycosis. Current Clinical and Diagnostic Status, L. Ajello, ed., Symposia Specialists, Miami, Fla. P. 201, 1977.
16. Huntington, R.W., et al: Acute Fatal Coccidioidal Pneumonia, in Coccidioidomycosis. Current Clinical and Diagnostic Status, L. Ajello, ed., University of Arizona Press, Tucson, p. 127, 1977.
17. Rowland, V., et al: Acute Respiratory Failure in Miliary Coccidioidomycosis. In Coccidioidomycosis. Current Clinical and Diagnostic Status, L. Ajello, ed., University of Arizona Press, Tucson, p. 139, 1977.
18. Castellot, J.J., et al: Fatal Miliary Coccidioidomycosis Complicating Prolonged Prednisone Treatment in Patient with Myelofibrosis, *Am. Int. Med.* 52:254, 1960.
19. Hileman, W.T., et al: Disseminated Coccidioidomycosis, Occurrence in Patient Receiving Steroid Therapy for Rheumatoid Arthritis, *Ariz. Med.* 20:268, 1963.
20. Knapp, W.A., et al: Fatal Coccidioidomycosis, Report of Two Cases, *Calif. Med.* 116:86, 1972.
21. Farness, O.J.: Some Unusual Aspects of Coccidioidomycosis, in Coccidioidomycosis, L. Ajello, ed., University of Arizona Press, Tucson, p. 23, 1967.
22. Winn, R.W.: Coccidioidomycosis, with Fungemia, in Coccidioidomycosis, L. Ajello, ed., University of Arizona Press, Tucson, p. 93, 1967.
23. Huntington, R.W.: Pathologic and Clinical Observations in 142 Cases of Fatal Coccidioidomycosis with Necropsy, in Coccidioidomycosis, L. Ajello, ed., University of Arizona Press, Tucson, p. 143, 1967.

● Dr. Allen, 1800 Barrs Street, Jacksonville 32203.

Increased Risk of Bacterial Endocarditis With Idiopathic Hypertrophic Subaortic Stenosis

John W. Klemme, M.D., and John F. Breen, M.D.

Abstract: The patient presented with a history of idiopathic hypertrophic subaortic stenosis (IHSS) which had been diagnosed several years previously. Evaluation confirmed the presence of bacterial endocarditis. The patient was treated with appropriate antibiotics and made an uneventful recovery. This case is presented to emphasize the increased incidence of bacterial endocarditis in patients with IHSS as well as to stress the need for prophylactic antibiotics in such patients when they are exposed to situations likely to result in bacteremia.

The association of idiopathic hypertrophic subaortic stenosis (IHSS) with bacterial endocarditis has been recognized since 1961.¹ However, only 27 cases of the coexistence of these two disorders have been reported in the English literature.¹⁻¹⁵ This case report is presented to reemphasize the risk of patients with IHSS of developing bacterial endocarditis.

Case Report

A 36-year-old man was admitted to James A. Haley Veterans Administration Hospital in Tampa, Florida on 3/7/80 with a four-week history of intermittent fevers, sweats, malaise, and weight loss. He had a history of a heart murmur detected during a sports physical at age 13.

The patient had been referred to this hospital in 1974 for evaluation of exertional "dizziness," hypertension, and a heart murmur. Cardiac examination revealed a grade 3/6 systolic murmur along the left sternal border with an S₄. Echocardiogram revealed septal hypertrophy with systolic motion of the anterior mitral valve leaflet. Cardiac catheterization was performed and a resting pressure gradient of 75 mm Hg was measured between the aorta and subaortic area. The gradient increased to 100 mm Hg with Valsalva's maneuver. The patient was informed he had IHSS and was discharged to the care of his private physician, who placed him on Inderal, Dyazide, Apresoline, and Valium.

The Authors

JOHN W. KLEMME, M.D.

Dr. Klemme is Resident in Internal Medicine, University of South Florida College of Medicine, Tampa.

JOHN F. BREEN, M.D.

Dr. Breen is Assistant Professor of Medicine, University of South Florida College of Medicine.

The patient was asymptomatic from 1974 until four weeks prior to admission, at which time intermittent fever to 40°C developed, also sweats, and malaise. There had been an 18-pound weight loss. He was initially treated by his private physician with a ten-day course of Vibramycin and improved on antibiotic therapy but the fever recurred. He returned to his physician who referred him to the James A. Haley VA Hospital.

There was no history of intravenous drug use. The patient denied dental procedures since his teeth were cleaned six months prior to admission. However, he did admit to brushing his gums daily with salt, use of dental floss and devices which utilize water under pressure to clean teeth. Until four months prior to admission he had felt well and could ride his bicycle 30 miles a day.

On admission the temperature was 38.5°C, blood pressure 128/75 mm Hg, pulse 72, respirations 18, and weight 96 kg. Carotid upstrokes were brisk and bifid. The PMI was cm to the left of the midsternal line in the fifth intercostal space. There was a presystolic impulse and a late systolic bulge was palpable. A grade 3/6 midsystolic murmur was present at the third interspace along the left sternal border. Closer to the apex the murmur became pansystolic and radiated to the axilla. It increased in intensity with Valsalva's maneuver and with standing. The lungs were clear. No splenomegaly, petechiae, splinter hemorrhages, clubbing, or embolic phenomena were present.

Laboratory data included: hemoglobin 10.8 gm; hematocrit 31.3%; WBC 12,500 cells/mm³ with 12 bands, 70 polymorphonuclear leukocytes, 7 monocytes, and 11 lymphocytes; urinalysis negative; sedimentation rate 54 mm; creatinine 1.1 mg/dl; and negative rheumatoid factor.

Electrocardiogram revealed sinus rhythm with left ventricular hypertrophy and an intraventricular conduction delay. Chest x-ray demonstrated mild cardiomegaly.

Six of six blood cultures were positive for alpha hemolytic streptococci sensitive to penicillin.

The patient was started on intravenous penicillin and intramuscular streptomycin and his subsequent course was uneventful.

Discussion

The incidence of bacterial endocarditis in patients

**Microbiology of 21* Patients With
Bacterial Endocarditis and IHSS.**

Organism	Number Patients
<i>Streptococcus viridens</i>	6 ^{1 5 8 10}
Alpha hemolytic streptococcus	3 ^{2 12}
<i>Streptococcus mutans</i>	2 ¹³
<i>Streptococcus pneumoniae</i>	3 ^{4 15}
Group D streptococcus	1 ¹⁵
<i>Streptococcus fecalis</i>	1 ⁶
<i>Enterococcus</i>	1 ¹¹
<i>Staphylococcus albus</i>	1 ⁴
<i>Staphylococcus aureus</i>	1 ⁹
<i>Listeria monocytogenes</i>	1 ¹⁴
<i>Diphtheroid bacillus</i>	1 ⁶

*Including the two patients from our series. The second patient had positive blood cultures for *Streptococcus pneumoniae*.

with IHSS has been obtained from data of several series and varies from five to nine percent.^{5 7 11} Frank and Braunwald⁵ reported three patients with bacterial endocarditis and three patients with suspected endocarditis out of 126 patients with IHSS. Of 22 patients with IHSS followed by Epstein and Coalshed,⁶ two cases of bacterial endocarditis were found. Swan, Bell, Oakley, and Goodwin⁷ noted four patients with bacterial endocarditis of 85 patients with IHSS. Wang, Gobel, and Gleason¹¹ reported two cases of bacterial endocarditis in their series of 26 patients with IHSS. This is the second case of bacterial endocarditis in our series of 34 patients with IHSS.

The heart valves involved have included the aor-

tic,^{3 5 8 10} mitral,^{1 4} and both the aortic and mitral.^{11 15}

In summary, although the increased incidence of bacterial endocarditis in patients with IHSS has been reported, there have been only 27 cases described in the English literature with both conditions present. A case report is presented to emphasize the need for awareness of this association as well as the need for prophylactic antibiotics in such patients who undergo manipulations which may produce bacteremia.

References

- Boiteau, G.M., and Allenstein, B.J.: Hypertrophic Subaortic Stenosis: Clinical and Hemodynamic Studies with Special Reference to Pulse Contour Measurement, *Am. J. Cardiol.* 8:614-623, 1961.
- Linhart, J.W., and Taylor, W.J.: Bacterial Endocarditis in Patient with Idiopathic Hypertrophic Subaortic Stenosis, *Circulation* 34:595-596, 1966.
- Nagle, J.P.: Idiopathic Hypertrophic Subaortic Stenosis and Bacterial Endocarditis, *JAMA* 200:163-165, 1967.
- Večht, R.J., and Oakley, C.M.: Infective Endocarditis in Three Patients with Hypertrophic Obstructive Cardiomyopathy, *Br. Med. J.* 2:455-459, 1968.
- Frank, S., and Braunwald, E.: Idiopathic Hypertrophic Subaortic Stenosis: Clinical Analysis of 126 Patients with Emphasis on Natural History, *Circulation* 37:759-788, 1968.
- Epstein, E.J., and Coalshed, N.: Bacterial Endocarditis in Idiopathic Hypertrophic Subaortic Stenosis, *Cardiologia* 54:30-36, 1969.
- Swan, D.A.; Bell, B.; Oakley, C.M., and Goodwin, J.: Analysis of Symptomatic Course and Prognosis and Treatment of Hypertrophic Obstructive Cardiomyopathy, *Br. Heart J.* 33: 671-685, 1971.
- Cardella, J.U.; Befeler, B.; Hildner, F.J., and Samet, P.: Hypertrophic Subaortic Stenosis Complicated by Aortic Insufficiency and Subacute Bacterial Endocarditis, *Am. Heart J.* 81:543-547, 1971.
- Chretien, J.H.; Limas, C., and Garagusi, V.F.: Association of Bacterial Endocarditis with Idiopathic Hypertrophic Subaortic Stenosis, *South. Med. J.* 66:269-272, 1973.
- Felix, J.; Bloch, A., and Duchosal, P.W.: Hypertrophic Subaortic Stenosis Complicated by Infective Endocarditis and Aortic Insufficiency: Hemodynamic Evaluation, *VASA* 2:238-242, 1973.
- Wang, K.; Gobel, F.L., and Gleason, D.F.: Bacterial Endocarditis in Idiopathic Hypertrophic Subaortic Stenosis, *Am. Heart J.* 89:359-365, 1975.
- Habibzadeh, M.A.; Curd, G.W., and Zeller, N.H.: Subacute Bacterial Endocarditis (SBE) Superimposed on Idiopathic Hypertrophic Subaortic Stenosis (IHSS), *Ariz. Med.* 33(10): 793-798, 1976.
- Robbins, N.; Szilagyi, G.; Tanowitz, H.B.; Luftschein, S., and Baum, S.G.: Infective Endocarditis Caused by *Streptococcus Mutans*, *Arch. Intern. Med.* 137:1171-1174, 1977.
- Pitcher, D., and Mary, D.: *Listeria Monocytogenes* Endocarditis in Hypertrophic Cardiomyopathy, *Br. Med. J.* 1(6118):961, 1978.
- LeJemtel, T.H.; Factor, S.M.; Koenigsberg, M.; O'Reilly, M.; Frater, R., and Sonnenblick, E.H.: Mural Vegetations at Site of Endocardial Trauma in Infective Endocarditis Complicating Idiopathic Hypertrophic Subaortic Stenosis, *Am. J. Cardiol.* 44:569-574, 1979.

● Dr. Breen, 12901 N. 30th Street, Tampa 33612.



SPECIAL ARTICLES

Physician Extenders in Florida

Richard J. Feinstein, M.D.

Abstract: Florida has statutory provisions and educational programs for both physician's assistants and advanced registered nurse practitioners. Laws that regulate the activity of physician's assistants are written in the Medical Practice Act, F.S., Chapter 458, and they demand close supervision by the licensed physician supervisor. Statutes which pertain to advanced registered nurse practitioners are found in the Nurse Practice Act, F.S., Chapter 464. The Board of Nursing has interpreted these statutes to allow independent medical diagnosis, treatment, prescription, and operation by nurses, who bill independently for provision of these services.

The federally funded Graduate Medical Education National Advisory Committee study recently concluded that there are presently too many physicians in the United States and that a surplus of close to 100,000 doctors can be expected by 1990. These findings repudiate a 20 year effort in the United States to increase the number of physicians. The effort has included such diverse enterprises as increasing the size and number of American medical colleges, priority immigration status for foreign medical doctors, and the education and certification of physician extenders.

The development of physician extenders was a natural evolutionary step for certain groups of health care workers at a time when physicians were thought to be in short supply. Registered nurses, military medical corpsmen, and a variety of other types of health care workers were all functioning within the health care system at high levels of expertise and professional responsibility. It seemed natural to institutionalize and legislate their importance to the health care team. They could be given additional legal responsibilities in caring for patients so that the licensed physician could deal with other more

sophisticated responsibilities of patient care. Two types of physician extenders developed at the same time in 1965: physician's assistant (PA), and advanced registered nurse practitioner (ARNP).

Physician Assistants

Dr. E. A. Stead Jr., started the first formal educational program for PAs at the Duke University Medical Center in 1965. He wanted to train health care workers who could assist busy community physicians in caring for their large patient populations. He also wanted to provide a career opportunity for medical assistants with a greater potential and respectability than the informally trained workers who assisted individual medical practitioners.

Most of the original applicants and students were retired military medical corpsmen whose practical experience in the field was their sole criteria for acceptance in the program. In time, the applicants changed from ex-medics to college students and college graduates. Most programs today require at least two years of college and many applicants are college graduates.

As time went on, other PA educational programs were started around the country. Almost all trained students in general medical educational experience, true to the concept developed at Duke University to prepare PAs to work as assistants for general practitioners. Florida has a single education program for PAs located at the University of Florida. The students, all of whom have some college experience, take part in the 24-month

The Author

RICHARD J. FEINSTEIN, M.D.

Dr. Feinstein is a member of the Florida Board of Medical Examiners and of the Joint Committee on Advanced Nursing Practice. He is Assistant Clinical Professor, Department of Dermatology, University of Miami School of Medicine, Miami.

program which exposes them to all specialty areas. After graduation each must pass the national physician's assistant certifying examination before qualifying for employment.

In Florida, the nationally certified PA must work with an individual licensed medical doctor. The physician and the PA must file a joint application with the Florida Department of Professional Regulation which reviews the application before referring it to the Board of Medical Examiners for inspection. This is done to make certain that the PA will be properly supervised by a physician or an alternate and will be performing only those tasks and procedures that the supervisory physician can competently perform himself.

The statutes which regulate the practice by PAs in Florida are found in the Medical Practice Act, Florida Statutes, Chapter 458. The supervisory physician is legally responsible for the work of the PA, and must supervise all activities unless the physician is not physically present when an emergency situation arises. In such situations, the PA must be able to communicate with the supervisory physician via an electronic device if he wishes to be available at the physician's medical facility for emergencies. Physician's assistants may not practice independently, and they must reapply to the Board of Medical Examiners if they leave the employment of one physician supervisor for another. Hospital based PAs must be certified to individual physicians or groups of physicians since they cannot be certified to institutions like hospitals, clinics, or emergency facilities.

Disciplinary action against a PA or a supervisory physician is handled by the Board of Medical Examiners after an administrative complaint has been filed by the Department of Professional Regulation. Physician's assistants may not: represent themselves as a physician, sign prescriptions, nor utilize prescriptions presigned by a physician. The Board at its March 1981 meeting fined a Florida physician \$4,000 and placed him on two years probation because his PA utilized presigned prescriptions.

Nurse Practitioners

The first educational program for nurse practitioners was started in 1965 at the University of Colorado Medical Center by Loretta Ford and Dr. Henry Silver to train pediatric ARNP. That first program and the ARNP concept it engendered were both successful and the nurse graduates were accepted enthusiastically by health professionals and health care institutions. Other ARNP educational programs attracted registered nurses who were seeking higher levels of professional responsibility and reward. Programs were started all over the country to help meet the health manpower needs of the geographic area or of individual health care institutions. State legis-

lators were petitioned to make changes in state laws to allow practice by advanced nursing graduates. Programs were tailored to train nurses for the requirements of individual specialty areas, which generally coincided with the recognized medical specialties. While the original Colorado program had trained only pediatric nurses, other programs developed to educate nurses to become ARNP in additional medical specialties.

Most states started at least one educational program in at least one specialty area but some states, like Delaware and Hawaii, still have no educational program or statutory provisions for advanced nursing specialists. Alabama is typical of many states which have limited statutory provision for ARNP. Their statutes allow for practice by nurse anesthetists and nurse midwives, and there are corresponding educational programs within the state. Florida is typical of the larger and more populous states which have greater statutory and educational commitments toward ARNP. The state has statutes which direct the Nursing Board to allow practice by nurse anesthetists, midwife, family, family planning, geriatric, pediatric, adult primary care, clinical specialists in psychiatric care, and other categories as determined appropriate by the Nursing Board.

The statutes which regulate the practice of ARNP are found in the Nurse Practice Act, Florida Statutes, Chapter 464. The law is administered by the Board of Nursing which may interpret the statutes and propose new rules related to advance nursing practice when the occasion arises. Any proposed rules for ARNP must first be approved by a joint committee composed of three members of the Nursing Board, three from the Medical Board, and a seventh neutral member, the Secretary of the Department of Professional Regulation, or her designate.

Registered nurses can apply to any of the educational programs around the country. State Boards of Nursing will generally certify any ARNP who has completed a recognized training program and has a registered nurse license within her state. There is presently no national certifying examination for any category of advanced nursing practice. There are two types of educational experiences that Nursing Boards will accept to fulfill the requirements for ARNP certification: source programs which train registered nurses in a specialty area of advanced nursing practice, and master's degree educational programs in nursing specialties. Nurses educated at a three year hospital nursing school, nurses with an associate of arts degree, and nurses with a baccalaureate degree may enter source programs for ARNP. These programs are typically one academic year or 10 months in length. Graduate nurses who hold baccalaureate degrees from four year colleges or universities may also enter a master's degree program.

Florida has several ARNP education programs: The University of Miami-Jackson Memorial Medical Center in Miami has programs in family practice, geriatrics, adult primary care, and midwifery. The University of South Florida in Tampa has an adult primary care program. The University of Florida School of Nursing in Gainesville has programs in adult health, child health, family health, pediatrics, and obstetrics-gynecology. Shands Hospital in Gainesville and Bay Memorial Medical Center in Panama City have educational programs for nurse anesthetists. All these are source programs of one academic year and certificate nurses in the specialty area in which they are trained. Master's degree programs are available at the University of Miami, University of Florida and other colleges in a variety of clinical nursing specialties. The course is a typical masters degree program usually of 30 credit hours. Some programs require presentation of a master's thesis while others require a six to 12 month residency program prior to granting a diploma.

After completion of the prescribed course, the nurse can apply to the Board of Nursing for certification as an ARNP. No examination, either national or statewide, is necessary.

The Nurse Practice Act states that, along with nursing acts, the ARNP "may also perform acts of medical diagnosis and treatment, prescription, and operation, which are identified and approved by a joint committee . . . Unless otherwise specified by the joint committee, such acts shall be performed under the general supervision of a licensed dentist, osteopathic physician, or medical doctor, within the framework of standing protocols which identify the acts to be performed and the condition of their performance."

At the present time, the Board of Nursing has passed no rules which require an ARNP to have a written protocol. The Nursing Board has also chosen not to enforce the statutory requirements for supervision of the nurse by a physician or dentist by not requiring the nurses to report the name of their physician supervisor to either the Board of Nursing or the Department of Professional Regulation. The Board has not asked the joint committee to consider approving any acts of medical diagnosis, prescription, treatment or operation for ARNP to perform, but instead has allowed such performance by making interpretations of the existing relevant statutes of the Nurse Practice Act.

It is known to the Nursing Board and to the general public that certain groups of ARNP are practicing medical diagnosis and treatment in an independent manner. These nurses are working at their own, or other free standing medical facilities in Florida, and they bill the patient or the patient's insurance carrier for the provision of service. In many of these situations the nurses do have a loose association with a licensed physician or

dentist, who has no legal responsibility for the acts performed by the nurse since the nurse is not in the physician's employment. There is no statutory provision in the medical or dental statutes concerning the supervision of ARNP. Such independent practice is uncommon but has been found in both rural and urban areas and is most prevalent for nurses who specialize in clinical psychiatric care or those specialty areas which pertain to women's health. Free standing women's health centers are extremely popular and various categories of ARNP perform counselling and family planning services such as the insertion and removal of intrauterine devices, and the prescription of oral contraceptives.

Legislative Intent

All legislation requires administrative interpretation, and all interpretation must take into account the intent of the legislature when it enacted the statutes. The Florida Board of Medical Examiners has sought to interpret the appropriate areas of the Medical Practice Act which relate to PA in a very defined and restrictive way, so as to agree with the philosophic and actual intent of the legislature when the members expressed a "concern with the growing shortage and geographic maldistribution of health care services in the state . . . to establish a new category of health manpower, the physician's assistant. The purpose . . . to encourage the more effective utilization of the skills of physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare."

Physician's assistants are physician's extenders in the true meaning of that term. They allow the licensed medical doctor to delegate tasks, when it is in the best interest of the patient, so that the physician can deal with other more complex problems of patient care. The legislation was written with such care as to preclude any abuse of the PA concept or practice by unscrupulous physicians or PA, who might be desirous of subjecting patients to substandard medical care for ulterior motives. The Board of Medical Examiners scrupulously investigates all physicians and their PA prior to certification and the law holds the physician legally responsible for activities of his PA. The statutes also insist that the PA will be thoroughly trained and tested prior to certification; demanding a 24-month educational program and the successful completion of a standardized national examination.

The Board of Nursing has chosen to interpret the legislative intent of the statutes which related to advanced nursing practice differently. The Nursing Board apparently believes that the legislature intended for nurses with 10 months of advanced training in a specialty area

to be able to practice medical diagnosis, prescription, treatment and operation at their own medical facilities. The Nursing Board apparently believes that the legislature was not as intent on preventing substandard medical care for patients who happened to get treated by ARNP as those who happened to become associated with PA. The legislature, wrote the Medical Practice Act and the Nurse Practice Act in the same legislative session, and both Chapters 458 and 464 became effective on January 2, 1980. It is difficult to understand why the legislature would be so careful about protecting the public from potential harm from association with a PA but not from an ARNP.

The Nursing Board also believes that the statutory reference to maintaining a standing protocol and having supervision of the ARNP by a licensed physician or dentist can be left entirely up to the integrity and honesty of the individual nurse, since the Nursing Board has made no attempt to enforce the statutes by requiring registration of protocols and the names of medical supervisors with either the Nursing Board of the Department of Professional Regulation.

Both physician's assistants and advanced registered nurse practitioners had their origins in 1965 to help physicians take care of patients. The concepts have diverged dramatically in the past 16 years. All PA and almost all ARNP do work as legitimate physician extenders; supervised and dependent health care workers who have become invaluable and indispensable for many segments of

the American health care system. Physicians, given authority by state laws to guarantee the health and safety of the citizens of their state, have scrupulously directed the course of the PA to ensure that they would follow their original philosophical goal, as well as the legislative intent, to serve the physicians in providing patient care, when that care was in the best interest of the patient.

Nursing groups, along with their friends in the legislature, on the other hand, have allowed ARNP to move in another direction by enabling them to practice independently without the careful scrutiny and supervision which would seem necessary for nurses and other dependent health care workers.

Bibliography

1. Fotler, M.D., et al: Physicians Attitudes Toward the Nurse Practitioner, *J. Health Soc. Behav.* 19(3):303-311, 1978.
2. Fotler, M.D.: Physicians Attitudes Toward Physician's Extenders, *Medical Care* XVII, No. 5, 536-549, May 1979.
3. Greenfield, S., et al: Efficiency and Cost of Primary Care by Nurses and Physicians' Assistants, *New England J. Med.* 298:305-309, 1978.
4. Heller, L.E., et al: Physicians' Assistants, New Prescribers, *Am. Pharm.* 18(13):12-17, 1978.
5. Levine, E.: What Do We Know About Nurse Practitioners? *Am. J. Nursing* 77:1799-1803, 1977.
6. Schoen, F.L.: Physicians Assistants and Nurse Practitioners, *Ann. Int. Med.* 92:126, 1980.
7. Sox Jr., H.C.: Quality of Patient Care by Nurse Practitioners and Physicians' Assistants: Ten-Year Perspective, *Ann. Int. Med.* 91:459-468, 1979.
8. Stead Jr., E.A.: Conserving Constly Talents — Providing Physician's New Assistants, *JAMA* 198:182, 1966.

- Dr. Feinstein, Suite 902, 3661 South Miami Avenue, Miami 33133.

Penicillinase-Producing *Neisseria* Gonorrhoeae in Florida

James T. Howell, M.D., M.P.H., and Jack E. Wroten, M.D.

A penicillin-resistant gonorrhea organism has emerged in Florida. It is a beta-lactamase producing strain of *Neisseria gonorrhoeae* which does not respond to traditional penicillin therapy.

Through the fourth week of March this year 53 cases of penicillin-resistant gonorrhea had been reported, more than for the previous four years. Last year there were 15 cases.

The patient with gonorrhea given the recommended dosage of penicillin and probenecid who returns in a few days complaining of the same symptoms as before treatment may be infected with the resistant organism.

At first it was believed that the organism was being brought into the state by individuals returning from Far East countries. Now, however, the source and spread have been identified locally.

Applied to public health clinics, the protocol to combat the infection and control its spread declares that patients and their contacts be brought to treatment rapidly. It consists of 2 gm spectinomycin IM. Epidemiology, applied immediately, begins with a confidential interview of the patient to obtain the names of sex partners exposed in the previous 30 days. Delay undoubtedly causes further spread.

The Department of Health and Rehabilitative Services' Venereal Disease Control Program has a representative near you who will be happy to assist in the epidemiology of penicillinase-producing *N. gonorrhoeae*. Please refer to the following list for his name.

The state laboratories will test isolates for beta-lactamase production. Cultures may be submitted to the branch laboratories located in Miami, West Palm Beach, Lantana, Orlando, Tampa, Tallahassee, Pensacola or to the central laboratory in Jacksonville.

These procedures are recommended for patients with uncomplicated gonorrhea:

1. Initially, nonallergic patients should be given aqueous procaine penicillin G 4.8 million units IM and 1.0 gm probenecid by mouth. Alternatively, 3.5 gm ampicillin and 1.0 gm probenecid are equally effective.
2. Three to five days posttreatment a test-of-cure culture should be obtained including male patients diagnosed by gram stain of a urethral smear.
3. Patients who have a positive test-of-cure culture should be treated with 2.0 gm spectinomycin IM. Repeat test-of-cure culture should be obtained three to five days after therapy. Patients should be advised to return four to six weeks after therapy for a rescreen culture.
4. All positive cultures should be screened for penicillin resistance by the beta-lactamase test.
5. Patients suspected of being infected with the penicillin-resistant organism should be investigated immediately. Their contacts should have throat and rectal as well as cervical or urethral cultures and prophylactic treatment with spectinomycin 2.0 gm IM. All positive cultures should be tested for penicillin resistance, i.e., beta-lactamase test. All contacts with positive cultures should have a test-of-cure three to five days post-treatment.

Venereal Disease Control Program

Representatives

Phillip A. Moncrief
Escambia County Health Department
2251 Palafox Street
Pensacola 32501
Telephone: (904) 438-8571

Counties: Bay, Escambia, Holmes, Okaloosa, Santa Rosa, and Washington

The Authors

JAMES T. HOWELL, M.D., M.P.H.

Dr. Howell is Staff Director, Health Program Office, and State Health Officer, Tallahassee.

JACK E. WROTEN, M.D.

Dr. Wroten is Chief, Venereal Disease Control Program, Jacksonville.

Robert W. Wilkinson
Ambassador Building, Suite 127-D
2005 Apalachee Parkway
Tallahassee 32301
Telephone: (904) 488-5982
Counties: Calhoun, Franklin, Gadsden, Gulf, Jackson
Jefferson, Leon, Liberty, and Wakulla

Willie H. Greene
Duval County Health Department
515 West 6th Street
Jacksonville 32206
Telephone: (904) 633-3620
Counties: Baker, Bradford, Clay, Columbia, Dixie
Duval, Flagler, Gilchrist, Hamilton, Lafayette
Madison, Nassau, Putnam, St. John
Suwannee, Taylor, Union, and Volusia

Curtis J. Childers
Marion County Health Department
1025 S.W. 1st Avenue
Ocala 32670
Telephone: (904) 629-0137
Counties: Alachua, Citrus, Hernando, Levy, Marion
and Sumter

Thomas Liberti
Pinellas County Health Department
500 Seventh Avenue South
St. Petersburg 33733
Telephone: (813) 894-1184
Counties: Pasco and Pinellas

David Cory
Hillsborough County Health Department
1105 East Kennedy Boulevard
Tampa 33601
Telephone: (813) 272-6396
Counties: DeSoto, Hardee, Highlands, Hillsborough
Manatee, Polk, and Sarasota

J. Howard Hill
Lee County Health Department
3920 Michigan Avenue
Ft. Myers 33805
Telephone: (813) 332-1747
Counties: Charlotte, Collier, Hendry, and Lee

Edward Carson
Orange County Health Department
832 West Central Boulevard
Orlando 32802
Telephone: (305) 420-3597
Counties: Brevard, Indian River, Lake, Orange,
Osceola, and Seminole

Thomas E. Burns
Palm Beach County Health Department
826 Evernia Street
West Palm Beach 33402
Telephone: (305) 837-3093
Counties: Glades, Martin, Okeechobee, Palm Beach,
and St. Lucie

Gerald J. Dunleavy
Broward County Health Department
800 W. Oakland Park Boulevard
Fort Lauderdale 33311
Telephone: (305) 561-1704
County: Broward

Joe C. Webb
Dade County Department of Public Health
1350 N.W. 14th Street, Building 4
Miami 33125
Telephone: (305) 325-2550
Counties: Dade and Monroe

- Dr. Howell, 1317 Winewood Boulevard, Tallahassee
32301.

Summary of Consensus Development Conference on CEA

A National Institutes of Health Consensus Development Conference on CEA (carcinoembryonic antigen): its role as a Tumor Marker in the Management of Cancer, was held at the National Institutes of Health September 29-October 1, 1980. The conference was sponsored by the National Cancer Institute, assisted by the Office for Medical Applications of Research, Office of the Director, NIH.

At NIH, Consensus Development Conferences bring together biomedical investigators, practicing physicians, consumers and others to provide a setting for the evaluation and review of the scientific soundness of a health or health-related technology, with an emphasis on safety and efficacy.

After two days of consideration of formal presentations by experts and comments by conference attendees, the Consensus Panel issued a statement reflecting its conclusions. This is a summary of that report.

Currently, measuring the levels of the tumor marker CEA in the blood of colorectal cancer patients is the best noninvasive technique for monitoring the disease after surgery. More studies are needed, however, before routine use of CEA can be advocated for monitoring patients with other types of cancer.

Many scientists have shown that CEA levels relate to the clinical stage of several types of cancer. CEA can help identify the disease stage and appropriate treatment, particularly in patients with colorectal or lung cancer. In addition, CEA is especially valuable in the continual mon-

itoring of colorectal cancer patients.

CEA should be measured in colorectal cancer patients before surgery. About six weeks after surgery, another plasma CEA sample can provide a baseline for monitoring the disease course, treatment, and prognosis. Within six weeks after surgery, previously elevated CEA should return to normal levels. Failure to do so points strongly to the continuing presence of cancer.

Radioimmunoassay tests have shown that small amounts of CEA also are present in the circulation of a healthy person. Higher CEA levels are not only characteristic of cancer, however; CEA levels can rise from smoking, benign tumors, and inflammatory disorders. Moreover, about 15-20 percent of patients with proved cancers never have increased CEA levels. Therefore, CEA assays should not be used in cancer screening for persons with no symptoms and assays should not be used independently to establish a diagnosis of cancer.

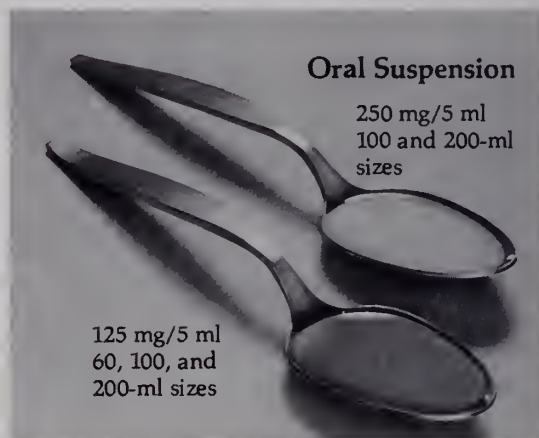
The usefulness of CEA in monitoring patients with other types of cancer is less convincing than it is for colorectal cancer. Future research should provide further insight into these questions. It also would be beneficial to pursue research that might improve the assay's usefulness, such as studying CEA in combination with other markers, and establishment of a laboratory quality control system using a CEA standard preparation.

Copies of the complete Consensus Development Panel Statement on CEA are available from the Office for Medical Applications of Research, National Institutes of Health, Building 1, Room 216, Bethesda, Maryland 20205.

AMA Meeting Convenes in Chicago

The Annual Meeting of the American Medical Association House of Delegates will convene Sunday, June 7, 1981, and continue through Thursday, June 11. The meeting will be held at the Downtown Marriot, Chicago, Illinois, and will include election of officers for the coming year. Among those whose names are to be placed in nomination will be Rufus K. Broadaway, M.D., of Miami, who will seek election as Vice Speaker of the House of Delegates as the nominee of the Florida Medical Association.

easy to take



Keflex®
cephalexin

Additional information available
to the profession on request.



Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630



Yes, Uncle Sam Needs You. Today, As Much As Ever.

The U.S. Army Medical Department is experiencing a shortage of physicians in its community hospitals and health clinics.

We are looking for dedicated physicians, physicians who want to be, not salesmen, accountants, and lawyers, but physicians. For such physicians we offer a practice that is practically perfect. In almost no time you experience a spectrum of cases some physicians do not encounter in a lifetime. You work without worrying whether the patient can pay or you will be paid. You prescribe, not the least care, not the most defensive care, but the best care.

A military physician practicing in the Southeast United States is afforded an opportunity for experience and leisure activities unlike nearly any other part of the U.S. If you like hunting, fishing, tennis, water sports, etc., outdoor activities combined with an excellent work environment we may have something for you.

The following is a list of the major Army Community Hospitals, in the Southeast, which have vacancies:

Fort Polk, Leesville, LA

Fort McClellan, Anniston, AL

Fort Benning, Columbus, GA

Fort Rucker, Dothan, AL

Fort Stewart, Savannah, GA

Fort Jackson, Columbia, SC

Redstone Arsenal, Huntsville, AL

Fort Bragg, Fayetteville, NC

Vacancies may vary as physicians arrive and depart but will exist in nearly every speciality at one medical facility or another. To obtain more information and vacancies by speciality please contact the Army Medical Department Personnel Counselor listed below. Be our guest at one of the above medical facilities or any other Army Medical facility.

WRITE OR CALL COLLECT:

MAJ Roger Baderschneider, MSC
3555 Maguire Blvd., Suite 250
Orlando, Florida 32803
(305) 896-0780

CPT Vivian Sheliga, MSC
DuPont Plaza Office Bldg., Room 711
300 Biscayne Blvd. Way
Miami, Florida 33131
(305) 358-6489

ARMY MEDICINE, BE ALL YOU CAN BE.

ORGANIZATION



T. Byron Thames, M.D.

T. Byron Thames, M.D.

A Year of Leadership

Louis C. Murray, M.D.

One of the continuing strengths of the Florida Medical Association is the unique infusion of talent it receives each year from its president. History will show T. Byron Thames to have been a leader among leaders.

Dr. Thames brought to the position of leadership as president a background of meritorious service. He had prepared himself by carrying out a multitude of responsibilities as a member and chairman of many councils and committees as well as serving five years on the Board of Governors. His prior service to organized medicine in other organizations included membership on the Board of Governors of Orlando Regional Medical Center, President of the Florida Academy of Family Physicians, Orange County Medical Society and the Florida Industrial Medical Association.

In private practice he is a modern day pioneer in developing the field of industrial medicine where he gained invaluable administrative and managerial experience. He serves as medical director for Walt Disney World, Sea World, Coca-Cola Foods Division, Orlando Utilities Commission and National Standard Life Insurance Company. And, in community life, he has served as president of the Orlando Rotary Club, on the Committee of One Hundred as the Central Florida Development Commission.

The benefits of all these prior accomplishments rapidly became evident as he took the gavel of leadership as our president and directed the affairs of the Board of Governors and the Association in general, in a highly organized executive manner. Byron proved to be a master at keeping the priorities of FMA in proper perspective. He always allowed sufficient time for indepth discussion of important matters, while not allowing unnecessary debate, demonstrating parliamentary skill in utilizing time for its best pursuits. It is therefore no wonder that the priorities of the Association for 1980-81 were carried out to completion in a most satisfactory and efficient manner.

The Author

LOUIS C. MURRAY, M.D.

Dr. Murray is a family practitioner in Orlando, and served as President of the FMA 1977-1978.

Byron's leadership ability made the complex look simple, the difficult appear easy and the seemingly impossible became possible.

Let's look at some of the objectives that became accomplishments during the year. Dr. Thames personally traveled throughout the state to increase communications with component medical societies and individual members. The long discussed Impaired Physicians Program is now a viable entity. FMA's councils and committees have been streamlined to better serve the membership.

In the area of governmental affairs, he rapidly established an excellent rapport with the Governor, legislative leaders and directors of public agencies. His organized, concise and expert articulation of the FMA position always resulted in a better understanding of the issues by all concerned. Byron was an able, clear spokesman for the Association in its relationship with the media, civic clubs and the public in general. His many meetings with the editorial boards of the communications media throughout the state, on the recovery of costs legislation and other priority FMA issues resulted in organized medicine being viewed in a more favorable posture by all Floridians.

Dr. Thames' selection of "Stress and Lifestyle" as the FMA theme during his year as president demonstrated his ability not only to identify that which is important now, but that which will continue to confront all of us in the future. The area of preventive medicine occupies an ever increasing sector of importance on the national medical and legislative scene and Byron used his crystal ball vision in defining the issue. This has resulted in a most comprehensive, quality program to be presented on the subject at the annual Scientific Session of the FMA for 1981.

It has also been my opportunity to observe that even as he served FMA "full time", Dr. Thames, in his organized manner, has pursued an active family life and industrial and family medical practice with equal zeal, concern and compassion. If a particular day was one to be filled with committee meetings, personal appearances, and activities relative to FMA, it was not unusual to see Byron beginning his rounds of two or three hospitals at 6:00

a.m., giving his patients the care he is so well known for.

In spite of all this, he still found time to maintain his own physical and mental well being with healthful outdoor activities, particularly tennis and hunting. We always notice the repertoire of jokes he tells with a humorous twinkle in his eye increased tenfold after one of his hunting trips. And, as a devoted family man, Byron always finds time to share with his lovely wife Pat, a former president of the FMA/A, and their children.

A composer of a fine musical score is endowed with the ability to bring together diverse, but complimentary components into a concerto of sound which is pleasing to all. Dr. Thames has exercised the same ability to coordinate all of our efforts to a similar goal; that of service to organized medicine and to the people who are served by it. Everyone has benefited from Byron's term as president. What more need be said?

Fifty Years Ago

In The Journal of the Florida Medical Association for April 1931:

Mead Johnson and Company advertised on the front cover: "The present spectacle of vitamin and irradiation advertising running riot in newspapers and magazines and via radio emphasizes the importance of the physician as a controlling agent in the application of vitamin products" . . . **Dr. T. Z. Cason** of Jacksonville was recently appointed to the Board of Governors of the American College of Physicians . . . The annual smoker of the Pinellas County Medical Society was held on March 9 at the Shrine Club in St. Petersburg . . . **Dr. W. J. Mayo** of Rochester, Minn., spoke on "Surgery in Relation to the Autonomic Nervous System" on March 6 in St. Petersburg . . . The Volusia County Auxiliary met in Deland on March 10 with poor attendance blamed on "bad weather and the busy season" . . .

And so it was in Florida medicine 50 years ago this month. — EDH.

K^{+} chLORide: wax maTRIX

SLOW-RELEASE TABLETS 10 mEq



KLOTRIX[®]
(POTASSIUM
CHLORIDE)

MeadJohnson
PHARMACEUTICAL DIVISION

DRAMATIC NEW CLINICAL PROOF*

In the treatment of impetigo—

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. No treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular.

(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but no failures with Tegopen.

		Given Tegopen® (cloxacillin sodium)	Given penicillin V-K
<i>Staphylococcus aureus</i> (78 patients)		39	39
Returned to clinic at one week	29†	38†	
Treatment failure at one week	0	18 (47.4%)	
<i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i> (9 patients)		4	5
Returned to clinic at one week	4	5	
Treatment failure at one week	0	2 (40%)	
No initial bacterial growth (14 patients)		9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic <i>Streptococcus</i> (1 patient)		0	1
TOTALS:	102 patients	52 patients	50 patients

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported

the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.

- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®

(cloxacillin sodium)

**—effective therapy for staph infections
of the skin and skin structures**

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose

stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®

Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201

Copyright © 1981, Bristol Laboratories

EIGHTH ANNUAL REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE

**"FUNDAMENTAL AND CLINICAL
ASPECTS OF INTERNAL MEDICINE"**

**SHERATON
BAL HARBOUR**

August 9 - 22, 1981

**MIAMI BEACH
FLORIDA**

Director: Maxwell McKenzie, M.D.

Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for *certification in internal medicine*. It will provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Twelve printed texts, references and self-assessment questionnaires will be provided to all registrants. Pictorial quizzes, patient management problems, videotape symposia and audiovisual teaching aids will be offered throughout the meeting. Upon request the twelve textbooks and self-assessment questionnaires will be forwarded to each registrant before the course begins. This course will end 23 days prior to the certification examination of the American Board of Internal Medicine, thereby providing time for assimilation.

Week I (August 9-15)

Cardiology
Pulmonary
Electrolytes — Renal
Hypertension — Critical Care
Neurology — Psychiatry — Radiology
Ophthalmology — Pharmacology — Toxicology
Dermatology — Laboratory — Geriatrics

Week II (August 16-22)

Endocrinology — Pathology
Infectious Disease — Immunology — Allergy
Rheumatology
Gastroenterology — Hepatology
Hematology
Genetics — Oncology — Nuclear Medicine

HIGHLIGHTS . . .

- | | |
|--|---|
| • Audio-Visual Aids | • Set of 12 Textbooks |
| • Pictorial Quiz | • Self-Assessment Questionnaires |
| • Self-Assessment Sessions | • Meet the Faculty Sessions |
| • Patient Management Problems | • Video Tape Symposia |
| • 88 Lecture Hours of Credit, Category I | • 65 Self-Instruction Hours of Credit, Category I |

Registration: \$650* Entire Course (August 9-22, 1981)
\$400 Week I (August 9-15)
\$400 Week II (August 16-22)

Enrollment must be limited because of extensive faculty/management interaction.

For registration and information write to:

Jose S. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760, Miami, Florida 33101
Phone: (305) 547-6063

*Includes tuition, set of textbooks, self-assessment questionnaires, use of audiovisual aids, library loan of T.V. tapes, cassette tapes and set of slides.

Medical News Around the State



Dr. Baker

Thomas J. Baker, M.D., of Miami . . . has been elected President of the American Society for Aesthetic Plastic Surgery, Inc.

Dr. Baker was chosen at the group's 14th Annual Meeting in Houston, Texas, to succeed another Floridian, **Bernard L. Kaye, M.D.**, of Jacksonville.

The new President is a graduate of the Indiana University School of Medicine and received residency training in surgery and plastic surgery at Jackson Memorial Hospital in Miami and the University of Texas School of Medicine. He is an Assistant Professor of Plastic Surgery at the University of Miami School of Medicine.

Samuel C. Bukantz, M.D., of Tampa . . . has been elected Secretary of the American College of Allergists. The election came during the College's 37th Annual Congress in Washington, D.C., April 4-8.

A graduate of the New York University School of Medicine, Dr. Bukantz is a Professor of Medicine at the University of South Florida College of Medicine and is Chief of Allergy at Tampa's Veterans Administration Hospital.

Robert J. Myerburg, M.D., of Miami . . . is one of 19 physicians nationally to be elected to three-year terms on the Board of Governors of the American College of Cardiology. As a Governor, Dr. Myerburg will provide liaison between the College and its members in the Miami area.



Dr. Gross

A specialist in cancer of children . . . has arrived in Gainesville to become Co-Director of Shands Teaching Hospital's new bone marrow therapy unit, the first of its kind in the southeastern United States.

He is **Samuel Gross, M.D.**, whose most recent activity was working in the bone marrow transplant program at Case Western Reserve University. Dr. Gross also will be Professor of Pedi-

atrics and Chief of the Division of Pediatric Hematology and Oncology in the University of Florida College of Medicine.

At the bone therapy unit at Shands, Dr. Gross will supervise the treatment of children receiving marrow transplants while his fellow co-director, **Roy Weiner, M.D.**, Chief of the Division of Oncology, will oversee adult patients in the new unit.



Dr. Aucremann

Charles E. Aucremann, M.D., of St. Petersburg . . . has been named Chairman of the Department of Family Medicine of the University of South Florida College of Medicine.

A native of Wheeling, W. Va., Dr. Aucremann received his M.D. degree from Emory University in Atlanta. He took gastroenterology and other graduate training at Georgia Baptist Hospital in Atlanta, Duval Medical

Center in Jacksonville, and the University of Pennsylvania Graduate Hospital in Philadelphia.

He has practiced privately in St. Petersburg since 1949 and was Chief of the Medical Service, Chief of Staff and Director of the Family Practice Residency Program at Bayfront Medical Center.

Dr. Aucremann's association with the University of South Florida began in 1974 when he became an Associate Professor of Family Medicine. Prior to his appointment as Chairman of the Department of Family Practice, he held that position in an acting capacity on two occasions.

**When painful spasm
is the presenting
symptom...**

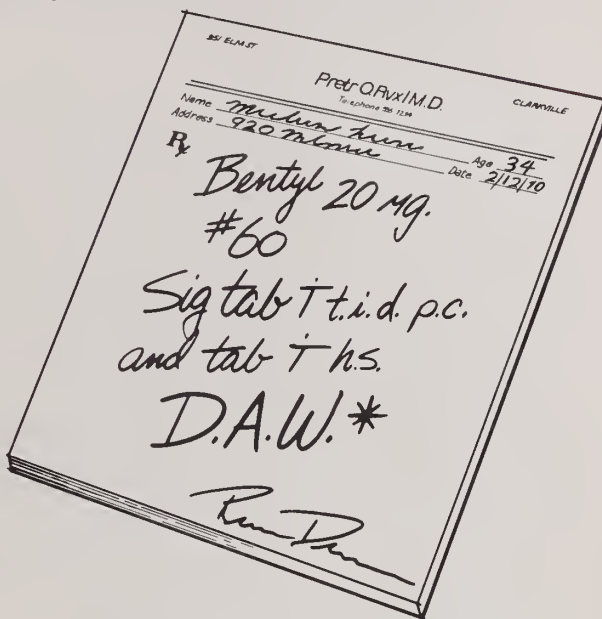


...in the functional bowel/irritable bowel syndrome[†]

be sure to specify

Bentyl[®]
(dicyclomine
hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injectable



**D.A.W.-Dispense as written*

because:

Bentyl passes these tests for product integrity.

- ⊗ The Bentyl molecule is a product of original Merrell research.
- ⊗ At Merrell, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊗ Bentyl bioavailability of tablets, capsules, syrup and injectable.
- ⊗ The bioequivalence of the oral dosage forms permits a choice of tablets, capsules, or syrup that satisfies patient's dosage preferences.
- ⊗ Pharmacologic effect in the distal colon compared to placebo^{††} shows how Bentyl affects abnormal motor activity in the irritable colon patient.[†]

[†] This drug has been classified "probably" effective for this indication.

Merrell

^{††} In the experiments that showed significant pharmacologic effect, the dose of Bentyl used was 50 mg. I.M., which is higher than that permitted in the labeling. This dose was deemed justified since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level that occurs after a single 50 mg. I.M. dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSEAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACAL COMPANY
Decatur, Illinois 62525 for
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Merrell

O-6546 (Y115C) MNQ 442

The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment

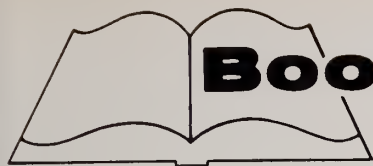


**CONVENTION
PRESS, INC.**

2111 NORTH LIBERTY ST.

**JACKSONVILLE,
FLORIDA 32206**

PHONE 904/354-5555



Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

(Editor's Note: Make up of a journal has its problems. Editorial decisions are often difficult. Because of these factors, book reviews for the months of February and March were omitted. Our Editor assures us that this section should thrive, prosper and enjoy longevity.)

Basic and Clinical Immunology, Third Edition. Edited by H. Hugh Fudenberg, M.D., Daniel P. Stites, M.D., Joseph L. Caldwell, M.D., and J. Vivian Wells, M.D. 782 Pages. Price \$17.50. Lange Medical Publications, Los Altos, California, 1980.

This represents the third edition of a text first offered in 1976. It is an updated presentation of basic concepts in immunology and of clinical entities with immunologic features. The book is designed for students and practitioners. Fifty-three contributors, many of whom are recognized authorities, have written the forty-four chapters and two appendices. The book is organized into sections of basic immunology, immunobiology, immunologic laboratory tests, and clinical immunology.

Subject material is discussed logically, thoroughly, accurately, clearly, and is generally up-to-date. Frequent and simple illustrative material enhance the text. The references provided at the end of each chapter are well-selected. As in any multi-authored text, some chapters read better than others and authors approaches vary (e.g., cytotoxic drugs in Sjogren's syndrome in Chapters 24 and 30). There are occasional oversimplifications of complex issues (such as functions of T_H and T_H cells, mitogen specificity of human T and B cell responses). The first three sections of the book (basic immunology, immunobiology, and immunology laboratory testing) should be of particular interest to the clinician attempting to keep abreast of newer concepts in immunology. The overview of the immune system, and discussions of cellular interactions, immunoregulation, and genetic control of immune response are particularly timely and well-done. The section on clinical immunology may be appropriate to students or generalists but will disappoint specialists or subspecialists. Descriptions of

several of the clinical entities are appropriate for the beginning student but not sufficiently detailed for the practicing clinician (for example, reviewing standard diagnostic criteria for rheumatic diseases would be useful). There is a tendency to present in absolutes when much of clinical medicine is less certain. There are occasional omissions (discussion of many of the newly-recognized autoantibodies, adult onset Still's disease).

Overall this is an excellent book. It succeeds admirably in presenting a timely, understandable, and thorough consideration of basic immunology and immunologic aspects of disease. It would be of value to students and to the clinician who is not a clinical immunologist yet is interested in immunology.

*Andrea Dlesk, M.D.
Gainesville*

*Richard S. Panush, M.D.
Gainesville*

Dr. Dlesk is a post-doctoral fellow in clinical immunology at the University of Florida, Gainesville. Dr. Panush is Associate Professor of Medicine and Immunology, and Medical Microbiology; and is Chief, Division of Clinical Immunology, University of Florida College of Medicine.

The Physician's Business Manual, by Richard M. Klass, 287 Pages. Price \$23.50. Appleton-Century Crofts, New York, 1981.

This very readable work on medical practice management is concise, yet encyclopedic in scope. Its author, a professional management consultant in the Miami area, has had extensive experience in evaluating numerous practice situations, and is obviously a professional. He has the unique ability to communicate patiently and in depth the most technical aspects of good office procedure in a manner which will hold the attention of the typical preoccupied practitioner.

Virtually every business aspect of a practice, from office security to the practical application of computer

Alert and
functioning
in the
sunset
years

Treat the symptoms in
the geriatric patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREbro-NICIN® capsule
contains:

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiimine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



technology is covered thoroughly in this well-illustrated book.

The young physician will benefit from such well discussed topics as "Choosing an Office: Location and Design" and "The Art of Beginning and Building a Medical Practice." The more established physician will appreciate the technical depth of such chapters as "Billing and Collection of Accounts Receivable" and "Office Efficiency Evaluation." Even the physician who considers himself an "old office hand" will find useful material in this book.

Kenneth L. Farrell, M.D.

Dr. Farrell is an otolaryngologist practicing in Ft. Lauderdale.

"Poisonous Snakebites in the United States" by Henry M. Parrish, M.D. 469 Pages. Price \$15.00. Vantage Press, Inc., New York, N.Y., 1980.

This book by Dr. Parrish of Ocala, Florida, recognized expert on poisonous snakebite, is not a book in the ordinary sense of the word. It represents primarily a reprint of the many articles which Dr. Parrish has published on the subject, mostly during the decade 1960 to 1969. A few of the papers in the book have not been previously published in journals. There is a semblance of conventional organization in that papers dealing with certain aspects of poisonous snakebite have been grouped together in chapters. Chapter 1, for example, contains reprints of papers which deal with the incidence of poisonous snakebite; Chapter 2 with death; Chapter 3 with incidence of snakebite by state; Chapter 4 with papers dealing primarily with diagnosis; Chapter 5 with treatment; and Chapter 6 with complications.

Since the great majority of papers were published between 1960 and 1969, the information contained in the book is somewhat dated, particularly that having to do with treatment. Because of the many controversies which continue to exist in the treatment of poisonous snakebite and the relatively high incidence of litigation associated with it, the fact that the reprinted papers are 10 to 20 years old could have detracted seriously from the value of the book. Fortunately, however, Dr. Parrish recognized many years ago what has now become almost universally accepted opinion, e.g. that cryotherapy is dangerous, that fasciotomy is unnecessary for most cases of snakebite and that the treatment of choice is antivenin. The epidemiologic data which Dr. Parrish has published continue to be cited by many authors and retain their validity.

Because of the nature of this book, there is considerable repetition in certain areas. In Chapter 3, for example, which deals with the incidence of snakebite by state and which encompasses 218 pages (or almost half the book), the grading system of severity of envenomation appears 44 times. Curiously, to avoid this kind of repetition the "Methods of Study" section in these individual papers has been deleted and the reader is referred to page 3 of the book. Similarly, detailed accounts of treatment have also been deleted, and reference is made to Chapter 5. As author himself points out there are some inconsistencies in the book due to the fact that it covers a 25-year period but I do not find these troublesome.

This book by Dr. Parrish contains much valuable information conveniently compiled under one cover and belongs in the library of any physician who might be expected to have to treat cases of snakebite.

L. H. S. Van Mierop, M.D.

Dr. Van Mierop is Professor, Department of Pediatrics (cardiology and Research), University of Florida College of Medicine, Gainesville. He has also contributed several articles on snakebite to *The Journal*.

Books Received

Receipt of the following books is acknowledged.

Microbial Diseases — Notes, Reports, Summaries, Trends compiled by Carl W. May. 322 Pages. Paperback. Illustrated. William Kaufmann, Inc., Los Altos, California, 1980.

Consumer's Guide to Cosmetics by Tom Conry. 376 Pages. Illustrated. Paper. Price \$3.95. Doubleday & Company, Inc., New York, 1980.

Mesmerism, A Translation of the Original Medical and Scientific Writings of F. A. Mesmer, M.D. 180 Pages. Price \$11.50. William Kaufmann, Inc., Los Altos, California, 1980.

The Doctors' Case Against the Pill by Barbara Seaman. 239 Pages. Paper. Price \$6.50. Doubleday & Company, Inc., New York, 1980.

Inadvertent Modification of the Immune Response edited by I. M. Asher, Ph.D. 319 Pages. Illustrated. Paper. The Office of Health Affairs, FDA, 1978.

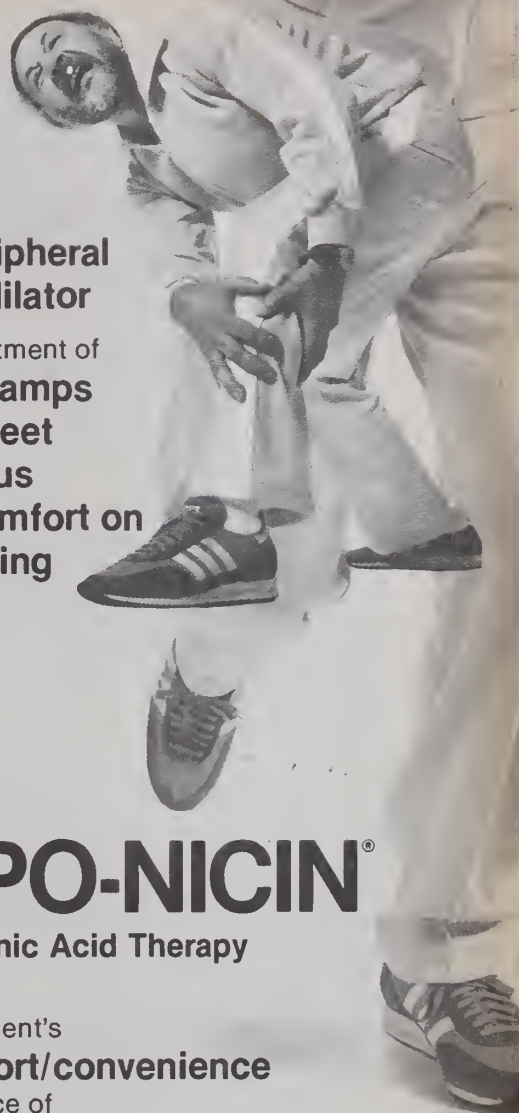
Born at Risk by B. D. Cohen. 212 Pages. Illustrated. Price \$9.95. St. Martin's Press, New York, 1980.

The Future of Pharmaceuticals by Clement Bezold, Ph.D. 142 Pages. John Wiley and Sons, New York, 1981.

The Physician's Business Manual by Richard M. Klass, M.B.A. 294 Pages. Appleton-Century-Crofts, New York, 1981.

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on
standing



LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	..... 300 mg.
Ascorbic Acid	..... 150 mg.
Thiamine HCL (B-1)	..... 25 mg.
Riboflavin (B-2)	..... 2 mg.
Pyridoxine HCL (B-6)	..... 10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	..... 250 mg.
Niacinamide	..... 75 mg.
Ascorbic Acid	..... 150 mg.
Thiamine HCL (B-1)	..... 25 mg.
Riboflavin (B-2)	..... 2 mg.
Pyridoxine HCL (B-6)	..... 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	..... 100 mg.
Niacinamide	..... 75 mg.
Ascorbic Acid	..... 150 mg.
Thiamine HCL (B-1)	..... 25 mg.
Riboflavin (B-2)	..... 2 mg.
Pyridoxine HCL (B-6)	..... 10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.


Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples


BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057





**Acute pain
is no laughing matter.**

**The first prescription for
the first days of acute pain**
Empirin® \bar{c} Codeine #3


Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). 

**For the millions of patients who need the potency
of aspirin and codeine for their acute pain.**

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin \bar{c} Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin \bar{c} Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin \bar{c} Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming.) 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSEAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

JUNE

Scientific Programs for Department of Family Practice, June 3, Naples Community Hospital, Auditorium, Naples. For information: Louis Dvonch, M.D., Box 2507, Naples 33940, Atten. Helen Taylor.

Eighth Annual Florida Perinatal Conference, June 5-6, Holiday Inn International, Orlando. For information: R. J. Boothby, M.D., 5720 Atlantic Boulevard, Jacksonville 32207.

14th Annual Physicians Workshop in Electrocardiography, June 9-16, Los Lebreros Hotel, Seville, Spain. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg, 33705.

Annual Homecoming Symposium (Psychiatry), June 12-13. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

6th Annual Suncoast Pediatric Conference, June 14-17, Sheraton Sand Key, Clearwater Beach. For information: Frank J. Cozzetto, M.D., c/o All Children's Hospital, Development Department, 801 6th Street South, St. Petersburg 33701.

FAFP 32nd Annual Scientific Assembly, June 17-21, Daytona Hilton, Daytona Beach. For information: Guy T. Selander, M.D., 1736 University Boulevard South, Jacksonville 32216.

Update on Oral Diabetic Agents, Artificial Pancreas, June 18, Doctors' Hospital of Hollywood conference room, Hollywood. For information: Jerome Rotstein, M.D., 1859 Van Buren Street, Hollywood 33022.

Non-Cardiac Surgery in the Cardiac Patient, June 18, Ft. Cooper Station Restaurant, Inverness. For information: C. J. McGrew Jr., M.D., 2875 Keyville Avenue, Spring Hill 33526.

Wyeth Autotutors, Florida Academy of Family Physicians 32nd Assembly, June 18-20, Daytona Beach Hilton Hotel, Daytona Beach. For information: Guy T. Selander, M.D., 1736 University Boulevard, South, Jacksonville 32216.

13th Family Practice Review, June 22-26, The Breakers, Palm Beach. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Cardiac Ischemia and Arrhythmias: Current Concepts for Diagnosis and Treatment, June 26-28, Dutch Inn, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood, Colorado 80112.

VI International Cuban Medical Association Congress, June 30-July 4, Sheraton Bal Harbour Hotel, Bal Harbour. For information: Manuel Viamonte Jr., M.D., 213 Aragon Avenue, Coral Gables 33134.

JULY

Cardiac Rehabilitation, July 24-25, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood 80112.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, (7th Annual Review Course), Aug., Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

ECG Interpretation and Arrhythmia Management, August 28-30, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood 80112.

SEPTEMBER

Indication and Implications of Office Pulmonary Function Testing, Sept. 17, Ft. Cooper Station Restaurant, Inverness. For information: C. J. McGrew Jr., M.D., 2875 Keyville Avenue, Spring Hill 33526.

OCTOBER

X-Ray Interpretation for the Primary Care and Emergency Physician, Oct. 1-4, St. Petersburg. For information: Sharon G. Llera, Administrative Assistant, Professional Services, Emergency Medical Services Assistants, 1400 66 Street, Suite 260, St. Petersburg 33710.

Parenting and Reparenting, Oct. 2, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Fort Walton Beach 32548.

APRIL

ECCE and IOL — Gills'-Welsh Extra Capsular Course, Oct. 3-4, April 11-12, May 16-17, St. Luke's Cataract and IOL Clinic, New Port Richey. For information: James P. Gills, M.D., 118 High Street, New Port Richey 33552.

NOVEMBER

Clinical Management of Coronary Disease and Exercise Testing, Nov. 6-8, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood, CO 80112.

The ABC's of Viral Hepatitis, Nov. 19, Ft. Cooper Station Restaurant, Inverness. For information: C. J. McGrew Jr., M.D., 2875 Keyville Avenue, Spring Hill 33526.

An apple a day won't keep alcoholism away!

The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

Do you have a patient who needs this kind of help? You probably do because the illness is sneaky. For more information and guidelines on how to identify these patients, write to us.

Willingway Hospital

311 JONES MILL ROAD
STATESBORO, GA. 30458

(912) 764-6236

J.C.A.H. ACCREDITED

Familial Ovarian Cancer Registry



There are increasing reports of ovarian cancer occurring in two (2) or more family members. The Familial Ovarian Cancer Registry will evaluate this increase to obtain information for genetic counseling to family members. Case accrual will evaluate:

- the number of cases of familial ovarian cancer
- the type of inheritance
- the relationship to breast and endometrial carcinoma
- the study of environmental, geographical and racial factors
- genetic counseling.

Please address inquiries regarding the clinical history of any family with two (2) or more members with ovarian cancer to:

Familial Ovarian Cancer Registry
M. Steven Piver, MD • Roswell Park Memorial Institute
New York State Department of Health • 666 Elm Street
Buffalo, New York 14263

Telephone: (716) 845-3110

MICROSURGERY COURSES

The Microsurgery Laboratory at the University of Florida offers three and five day courses aimed at teaching techniques applicable to:

- Extracranial to Intracranial Bypass
- Digital Reimplantation
- Tubal Reanastomosis
- Vasovasostomy
- Transsphenoidal Surgery
- Temporal Bone Dissection
- Other Microsurgical Operations

For Information write:

Mrs. Cindy Brady
Microsurgery Laboratory
Box J265
University of Florida Health Center
Gainesville, FL 32610

**REINSURANCE
BROKERS for
Florida Physicians
Insurance Reciprocal
—serving physicians
throughout Florida**



**The
Wetzel
Company,
Inc.**

P.O. Box 66452 · Houston, Texas 77006

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

MEDICAL OPHTHALMOLOGIST wanted for busy practice. No refraction or contact lens fitting. Ideal location in East Coast of Florida. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

WELL TRAINED Family Practitioner or Internist needed to join staff of a Family Medical Center in Jacksonville, Florida. Excellent opportunity for professional and economic growth. Respond with CV to: Susan Masterson, Emergency Medical Services Associates, Inc., 8200 W. Sunrise Boulevard, Building C, Plantation, Florida 33322, or phone (305) 472-6922.

FULL-TIME CAREER-ORIENTED Emergency Physicians to work in busy Dade County Emergency Departments with an old, established group. Liberal salary with bonus incentives. Send C.V. to: Emergency Physicians, Post Office Box 160429, Miami, Florida 33116.

SURGEON — General, Vascular, Thoracic — Non-cardiac — needed as independent or associate in small town bordering Orlando. Send CV and references to C-1044, P.O. Box 2411, Jacksonville, Florida 32203.

LOCUM TENENS — Diagnostic Nuclear, Ultrasound, Radiology Department. Coastal Northeast Florida — Summer and/or Fall months — May lead to

association. Contact: J.L. Castillo, M.D., P.A., Post Office Drawer N, Fernandina Beach, Florida 32034.

PHYSICIAN WANTED to share office expenses with internist. Brand new office in Boca Raton, Florida. Reply C-1045, Post Office Box 2411, Jacksonville, Florida 32203.

EMERGENCY CLINIC, Tampa, Florida — Family practitioner or emergency physician for free-standing emergency clinic. No nights. No hospital responsibilities, new facilities. Send C.V. to Stephen F. Dickey, M.D., P.O. Box 18765, Tampa, Florida 33607. Phone: (813) 877-8450.

FLORIDA, Tampa/Brandon area, physician wanted for family practice. Excellent opportunity for partnership. Looking for energetic, professional individual. Contact Shelton E. Sharpe, III, M.D., 305 South Bryan Road, Brandon, Florida 33511. (813) 813-1350.

GENERAL INTERNIST or General Practitioner wanted for a practice which consists primarily of general Internal Medicine, but also includes some family practice and industrial medicine. The position would be ideal for an American well trained physician who is seeking good hours, excellent working conditions, is willing to work hard and yet wants a substantial amount of free time. Please send C.V. and recent photo to: Jan A. Becker, M.D., 727 Vassar Ave., Orlando, Florida 32804.

PSYCHIATRIST, Board Eligible, needed on Florida's Suncoast. Comprehensive Community Mental Health Program with 100 staff and budget of two million dollars. Send resumes or inquiries to Human Development Center of Pasco, Inc., P.O. Box 428, New Port Richey, Florida 33552.

GENERAL SURGEON, ENT, Urologist, Gastroenterologist — wanted to join with Internist, OB-GYN and Pediatric Group as tenants in Boca Raton, Florida's newest, most prestigious Professional Building adjacent to new 900,000 square

foot Town Center Mall. Contact Dr. Robert A. Uchin, D.D.S. (305) 566-7692.

WANTED — Board eligible or Board certified Psychiatrist for full- or part-time employment at Community Mental Health Center. Duties would include medication clinic, psychiatric evaluations, etc. Salary negotiable. Please send curriculum vitae to: Robert K. Quam, Exec. Dir., Human Resources Center, 1220 Willis Avenue, Daytona Beach, Florida 32014.

COUNTY HEALTH UNIT DIRECTORS — (Hernando, Citrus, or Columbia County) Must have Florida license as Dr. of Medicine or Osteopathy, public health training and/or experience. Send resume/application to Gail Crawford, HRS, 2002 N.W. 13th Street, Gainesville, Florida 32601. Affirmative Action/Equal Opportunity Employer.

INTERNIST WANTED to associate with established physician in Jacksonville. Excellent remuneration and immediate full partnership. Cardiology experience required. Reply C-1052, Post Office Box 2411, Jacksonville, Florida 32203.

FLORIDA — Pediatrician to share in an active, fully equipped practice in Hollywood, Florida with immediate sharing of facilities and partnership. Excellent nighttime coverage. Send C.V. to C-1054, Post Office Box 2411, Jacksonville, Florida 32203.

EXCELLENT opportunity due to an unexpected opening for a Medical Oncologist to take over an established practice in a 25 man multispecialty group. Florida West Coast. Excellent income with growth potential. Must be board certified (or eligible) and available during or before July. Send C.V. immediately to C-1055, Post Office Box 2411, Jacksonville, Florida 32203.

FLORIDA — Aggressive group, fee-for-service, malpractice, group health insurance, teaching, EMS, opportunity for advancement. Contact Steve Watsky, M.D., 707 40th Street West, Palmetto, Florida 33561, (813) 722-1722 or P. Fagan Jr., M.D., P.O. Box 9639-FL, Marina Del Rey, California 90291, (213) 822-1312.

LOCUM TENENS — COMP-HEALTH. Our medical group can provide a well qualified physician to cover your practice in your absence. For information, please write or call T.C. Kolff, M.D., Comprehensive Health Systems, Inc., 175 West 200 South, Suite 2003, Salt Lake City, Utah 84101, (801) 532-1200.

EMERGENCY MEDICINE opportunities throughout Florida: Directorship and clinical positions available to career-oriented emergency physicians in central and coastal areas. Excellent compensation, paid professional liability insurance, flexible scheduling to be awarded to physicians chosen. For details send credentials in complete confidence to Mary Obsitnik, 9100 Purdue, Suite 119, Indianapolis, IN 46268; or call collect (317) 875-7518.

MULTISPECIALTY GROUP: Recruiting for positions in pediatrics, ENT, general/vascular surgery with board eligibility or certification in thoracic surgery and orthopedics. Qualified candidates may notify Administrator, Palm Beach Medical Group, 705 North Olive Avenue, West Palm Beach, Florida 33401.

PHYSICIAN'S ASSISTANT: The Department of Neurosurgery at the University of Florida is recruiting a physician's assistant to work with the Neurosurgical Faculty. The recruiting deadline is June 1, 1981 with an anticipated starting date of June 15, 1981. Applicants must have a degree from an accredited Physician's Assistant Program. Duties will include routine ward care, assisting in surgery, and history and physical examinations. For more information contact: J. Parker Mickle, M.D., Department of Neurosurgery, Box J-265, JHMC, Gainesville, Florida 32610. Equal Employment/Affirmative Action Employer.

FAMILY PHYSICIANS desperately needed to locate in West Central Alabama rural communities, one hour from Birmingham. Faculty appointment with Family Practice Center at University of Alabama if qualified. Join established practice or work individually. Salary guaranteed until practice is self-sufficient. Generous fringe benefits include life, disability, health, retirement, and malpractice insurance, two weeks continuing education, and three weeks annual leave. All equipment, including X-rays and lab, furniture and supplies provided. Management services including personnel, payroll, tax reports, and billing provided. If invited to visit, all expenses

will be paid. All moving expenses covered. Write Health Development Corporation, P.O. Box 1486, Tuscaloosa, Alabama 35403, or telephone Frank Cochran collect at 758-7545 for more information.

Situations Wanted

GENERAL, COLON AND RECTUM SURGEON, trained in Colonoscopy, Board eligible, 35, seeks position in Florida to practice either one specialty or both. Speaks Spanish fluently. Available October 1981. Contact: Luis F. Espallat, M.D., 1517 Texas Avenue, Homestead AFB, Florida 33039. Phone (305) 257-2870.

JOHN L. DRISCOLL, M.D. — General Surgery Resident; CMDNJ/Board Eligible; holds current Florida Medical Licensure; seeking General Surgery practice, group or partnership; available July 1981. Reply: 631 Avenue E, Bayonne, New Jersey 07002.

INTERNIST SEEKING immediate practice opportunities in Dade/Broward County. Will consider part-time, E.R., or buying practice. Write: Sailesh M. Dave, M.D., P.O. Box 69-3005, Miami, Florida 33169.

PATHOLOGIST — 36 years. University and broad experience in 800 bed hospital. Certified Anatomic and Clinical Pathology. Desires relocation in Florida. Prefer hospital based or group position in Gulf Coast area. Reply: C-1046, Post Office Box 2411, Jacksonville, Florida 32203.

FAMILY PRACTITIONER, 37, residency trained, Board certified, Florida license, bilingual, seeks private practice or group opportunity in Coastal or Central Florida. Would also consider joining or establishing Weight Control Clinic. Available Summer or Fall 1981. Reply: Box 231, Alta Loma, California 91701.

INTERNIST, BOARD Eligible, Florida licensed. Floridian desires relocation in Florida. University trained; one year clinical pulmonary disease. Academic background. Experience in solo and group practice and corporate medicine. Available about July 1, 1981. For CV and information contact: Harry A. Edwards, M.D., days — (615) 327-2520, evenings — (615) 446-6714. Rt. 2, Box 41, Burns, Tennessee 37029.

38-YEAR OLD BOARD CERTIFIED Internist-Hematologist Oncologist planning to relocate in the state of Florida. Particularly interested in either group practice or partnership. Contact by mail Paul Aronsohn, M.D., 4036 Foxlake Drive, Bloomfield Hills, Michigan 48013.

AMERICAN trained, psychiatrist and family practitioner seeking creative and challenging administrative/clinical position. 43 years old and experienced in the fields of clinical and administrative medicine and psychiatry. C.V. on request. Oscar Klein, M.D., 96 Chapel Hill Road, Highland, New York 12528. Telephone: (914) 691-2330.

UROLOGIST. University trained with extra year fellowship. Board Eligible. Private solo practice for three years — wishes to relocate. Partnership considered. Florida licensed. Married. Request C.V. to C-1048, P.O. Box 2411, Jacksonville, Florida 32203.

GASTROENTEROLOGIST — Internist, Board Certified, age 41, Florida license, wishes to relocate to the metropolitan area in Florida. Request C.V. to C-1049, P.O. Box 2411, Jacksonville, Florida 32203.

PSYCHIATRY: Clinically oriented 34 year old Psychiatrist in successful solo practice with wide consultation experience (including CMHC, Forensic Psychiatry and contract teaching of F.P. Residents) seeks group practice or interesting consultation opportunities in Miami / Fort Lauderdale. C.V. on request. C-1050, P.O. Box 2411, Jacksonville, Florida 32203.

MEDICAL OPHTHALMOLOGY: 43 year old American Board certified, desires satisfactory position in established practice. Will consider all locations. Curriculum Vitae on request. C-1051, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIAN ASSISTANT graduating University of Florida, available 7/6/81, seeks Family Practice, Emergency Room, or Cardiology position in the Jacksonville area. C.V. available on request. Contact Lance Mathis, 3530-90 S.W. 24th Avenue, Gainesville, Florida 32608.

GENERAL SURGEON with G.I. endoscopy experience interested in trauma. Completed training in 1979. Seeking a surgical group or Multispecialty Clinic. Available September 1981. Will

consider organizing multispecialty group. Write: E.C., 3711 Lonniewood Drive, Houston, Texas 77059.

INTERNIST-PULMONOLOGIST, 33, University Hospital trained in Bronchoscopy, I.C.U., P.F.T., Swan-Ganz. Wife physiatrist University trained. Seeking job or practice after July 1981. Reply C-1034, P.O. Box 2411, Jacksonville, Florida 32203.

Practices Available

MEDICAL OFFICE AVAILABLE JULY 1981, 475 Biltmore Way, Coral Gables; 1,000 square feet. All furniture, fixtures and equipment ready for sale intact to lessee. Functional, tasteful office, "ready to go" for specialist or generalist or new physician. Call 443-8767 or 665-1713 after 5.

PRACTICE AVAILABLE — Because of disability retirement, an Internal Medicine and Pulmonary Disease practice is available immediately. Includes all equipment and approximately 400 active patient files. Northside St. Petersburg, Florida location. Call today, Jim E. Hartley, Broker/Salesman, The Crisp Company, Realtors, (813) 822-9119 for viewing and details.

GENERAL PRACTICE FOR SALE, growing area, Pinellas County; same location 20 years; also, possible association. Gonzalez, M.D., (813) 443-2104 after 7 p.m. or write P.O. Box 1286, Clearwater, Florida 33517.

GENERAL INTERNAL MEDICINE Practice — 3½ years: for sale, active; adjacent to 350-bed hospital. Going back to Country of Origin. Easy terms. 4-BR home in prestigious location available. Practice and home descriptions give per request. Reply: 1400 74 Circle N.E., St. Petersburg, Florida 33702; Telephone (813) 522-4611, after 7 p.m.

ESTABLISHED INTERNAL MEDICINE Practice with fully equipped office for sale. Excellent location in North Miami Beach, Florida — near hospitals. Negotiable terms. Reply: C-1053, Post Office Box 2411, Jacksonville, Florida 32203.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

MEDICAL FACILITY downtown Orlando near all hospitals. 1493 feet includes X-ray, exam rooms, etc. Free use of \$60,000 worth of medical equipment. Sacrifice \$900 month. (305) 425-2843 or 351-5885.

ORLANDO, FLORIDA — Lease: Brand new construction, medical-dental-professional. Prestigious location in Tusawilla Community. Interior ready to be designed to your specifications. 1,000 to 2,000 square feet suites available. Contact: Ray Chimento, Box 9168, Union Park, Florida 32817. (305) 282-1111.

PRIME FARM and Timber Land. 2 tractor, 600 acres and 400 acres. Central Alabama. Must sell. \$1,000 an acre. Contact Marvin Johnson, M.D., 900 Avenue, M.S.E., Winter Haven, Florida 33880.

LAKELAND, FLORIDA. Medical office space available in Professional Village; central Florida location. Colleges, retirement community, and industries create interesting environment for practice. 1424 square feet, can be partitioned to suit. Available as rental or purchase as condominium. Contact Edwin R. Lahm, M.D., (813) 682-3672 or 665-5773.

WEST PALM BEACH: Located in a new, fast developing area, 200 yards east of I-95 exit, adjoining The Community Hospital of the Palm Beaches and near St. Mary's hospital. Medical Suites: From 3 to 6 examining rooms, business office, waiting room, and consultation rooms. Storage closets, built-in office desk cabinets, multi drawer work area cabinet with sink, wash basins in each examining room, extensive parking. Contact: Community Professional Building, 2151 45th Street, West Palm Beach, Florida 33407. (305) 842-5023.

RAPIDLY GROWING GULF-COAST — New Port Richey, Florida — For Rent, two offices in Medical Building — across from 450 bed hospital — ideal

physician office and location. For information write to: Post Office Box 475, New Port Richey, Florida 33552. Phone (813) 849-6525.

OUTSTANDING LOCATION — Professional office space for rent. Multi-specialty building adjacent to modern 225 bed Medical Center emergency room. Contact Post Office Box 4082, Fort Pierce, Florida 33454. Phone: (305) 465-7060.

FULLY EQUIPPED office will be available after May 1st 1981. Centrally located beach side, Daytona Beach. If interested call (904) 252-0910 or (904) 677-6807.

SANFORD, FLORIDA — Near new hospital. Will build doctor's offices to suit. 3,500 square feet. Long term lease. For additional information call (813) 971-8503 or write 14910 Lake Forest Drive, Lutz, Florida 33549.

TO SUBLET — Medical office space in prime Medical Office Building. Convenient to St. Joseph's and Women's Hospital, 4700 N. Habana Avenue, Tampa, Florida; 15550 square feet, well partitioned office, four exam rooms, two consultation rooms, lab and business office. Suitable for almost any specialty. Call (813) 877-7434.

Equipment

REMODELING? RETIRING? NEW physician looking for used office furniture, exam table and equipment to set up part-time practice in adolescent medicine and psychiatry. Contact R.S. Smith, M.D., Box 606, Ocala, Florida 32678, (904) 629-8893.

WE BUY, SELL, and lease new and used Medical Instrumentation: EKG's, lab. Holter Monitors, Stress Test, Echo, etc. Contact: New Life Systems, Inc., Ed Bentolila, P.O. Box 8767, Coral Springs, Florida 33605. (305) 753-9961.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Col, 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Services

GOLD AND SILVER — Inflation Hedge and only real money. Buy or sell. Contact: Au, M.D. — E.K. House, M.D., 629 West Broad Street, Brooksville, Florida 33512.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.



Two convenient dosage forms: 100 mg (white) and 300 mg (peach) Scored Tablets



Tablets imprinted with brand name to assist in tablet identification.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

When
impotence
is due to androgenic deficiency.

Android® 5^{Buccal} / 10^{Oral} / 25^{Oral} mg

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of male climacteric / eunuchoidism, eunuchism / post-pubertal cryptorchidism.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., I. B. Sipahoglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

Write for new double blind study reprints and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Advertisers

Anderson-Clayton Foods		Merrel-National	
New Age Sandwich Slices	344	Bentyl	388
Bristol Laboratories		Tenuate	354a
Tegopen	384	Numismatic Investments of Florida	
Brown Pharmaceuticals		Investments	340
Cerebro-Nicin	392	Reed & Carnrick	
Lipo-Nicin	393	Dilatrate-SR.	386a
Android	401	Roche Laboratories	
Burroughs Wellcome		Valium	349
Zyloprim	401	Bactrim	403
Empirin \bar{c} Codeine	394	Limbital	338
Convention Press		Librax	354a
Service	390	Sequoia Group, Inc.	
DAC Corporation		Medical Systems	354a
Service	354	Smith Kline and French	
Florida Medical Foundation		Dyazide	386a
Fruit	354	University of Florida	
Florida National Banks		Meeting	396
Service	353	University of Miami	
Geriatric Pharmaceutical Co.		Meeting	386
Iso-bid	342	U.S. Army	
Hedeco		Recruitment	379
Entero-test	352	The Upjohn Company	
Janssen Pharmaceutical		Motrin	386a
Vermox	356	Wetzel	
Eli Lilly & Company		Service	397
Keflex	378	Willingway Hospital	
Mead Johnson		Service	396
Klotrix	383	Wyeth Laboratories	
		Cyclapen	350

Florida Medical Association Officers and Council Chairmen

Officers

T. Byron Thames, M.D., Orlando, President
Sanford A. Mullen, M.D., Jacksonville, President-Elect
Gerold L. Schlebler, M.D., Gainesville, Vice President
Robert E. Windom, M.D., Sarasota, Secretary
J. Russell Forlaw, M.D., Boynton Beach, Treasurer
Richard S. Hodes, M.D., Tampa, Immediate Past-President
James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation and Regulations
William W. Thompson, M.D., Ft. Walton Beach, Health Care Financing
Joseph T. Ostroski, M.D., Miami, Medical Services
Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
Dick L. Van Eldik, M.D., Lake Worth, Specialty Medicine

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION



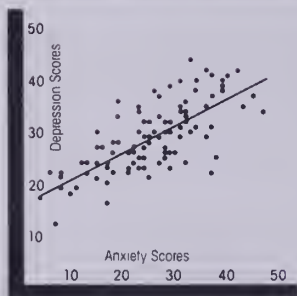
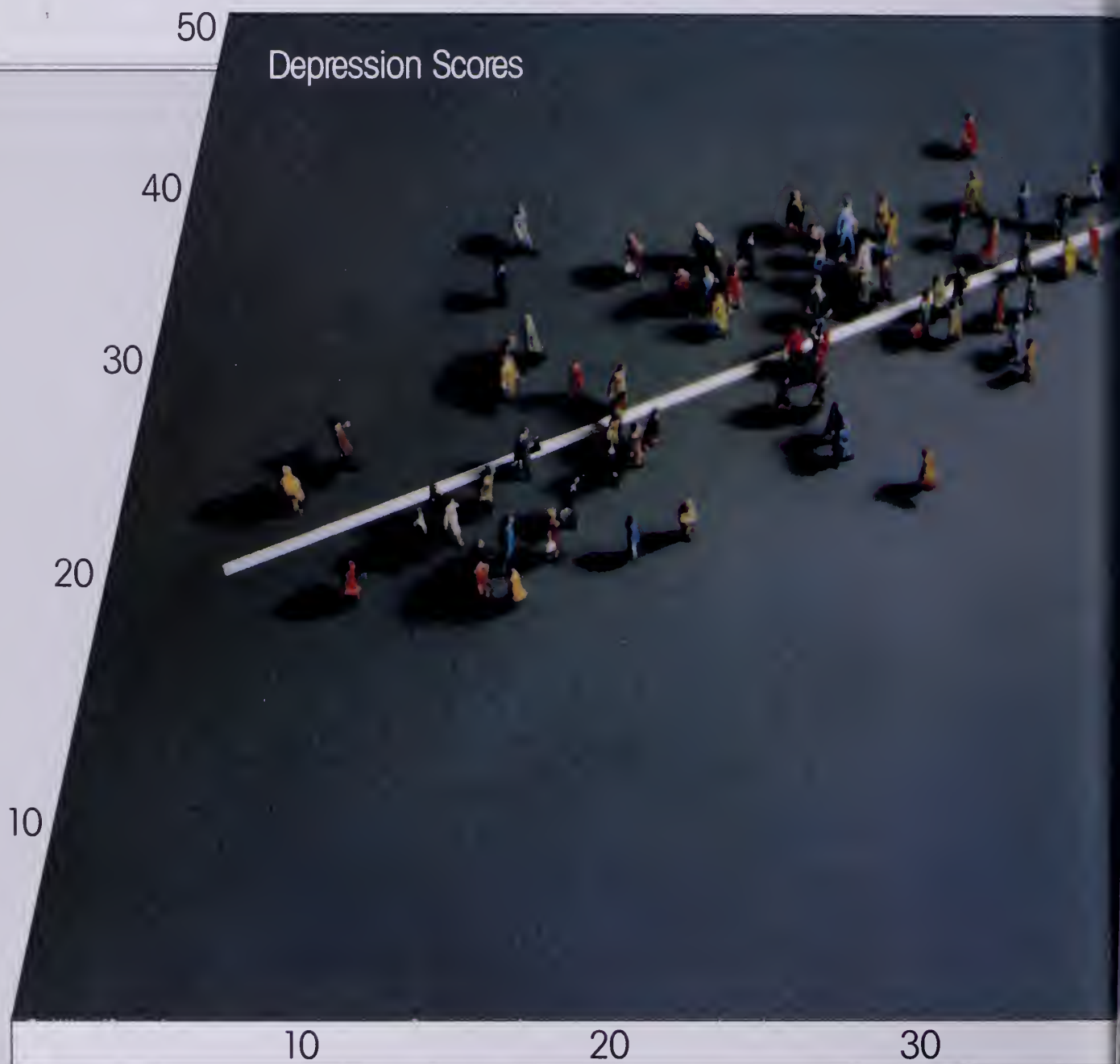
JUNE 1981 • VOL 68 • NO. 6



Sanford A. Mullen, M.D.
105th President of the Florida Medical Association

RECEIVED
JULY 1981
JULY 2 1981

FOR THE 7 OF 10 NONPSYCHOTIC



Clear correlation between anxiety and depression³

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

³Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics* 11:438-441, Sept-Oct 1970.

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS^{1,2}

Most depressed patients are also anxious. . .

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.^{1,2} One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.³ As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.⁴ Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.⁵ Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. 2. Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry* 35:1359-1365, 1978. 3. Claghorn J: The anxiety-depression syndrome. *Psychosomatics* 11:438-441, 1970. 4. The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry* 137:1163-1172, 1980. 5. Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology* 61:217-225, 1979.

Anxiety Scores

50

In moderate depression and anxiety

Limbitrol®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquillizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies.

Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated—sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecostasia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine mesylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment



**CONVENTION
PRESS, INC.**

2111 NORTH LIBERTY ST.
**JACKSONVILLE,
FLORIDA 32206**

PHONE 904/354-5555



ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

JUNE 1981 • VOL 68 • NO. 6 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.
E. Charlton Prather, M.D.

Assistant Editors

Francis C. Coleman, M.D.
James K. Conn, M.D.
Lee A. Fischer, M.D.
Norman M. Kenyon, M.D.
(from Board of Governors)
Edward Pedrero Jr., M.D.

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Susan L. Milhoan

Consulting Editorial Staff

Fuad S. Ashkar, M.D.	R. G. Lacsamana, M.D.
Thomas D. Bartley, M.D.	Richard F. Lockey, M.D.
Robert L. Batey, M.D.	Philander D. Morgan, M.D.
Pierre J. Bouis Jr., M.D.	George Morris, M.D.
Ms. Deborah B. Wilbur	George A. Nader Jr., M.D.
William T. Branch, M.D.	Richard S. Panush, M.D.
Miguel A. Brito, Jr.	R. A. Penalver, M.D.
Elmer B. Campbell, M.D.	John K. Petrakis, M.D.
Manuel L. Carbonell, M.D.	Phillip B. Phillips, M.D.
Ronald W. Case, M.D.	Michael R. Redmond, M.D.
Louis E. Cimino, M.D.	Albert L. Rhoton, M.D.
Charles Craig, M.D.	James F. Richards Jr., M.D.
R. Jay Cummings Jr., M.D.	Arvey I. Rogers, M.D.
Raul deVelasco, M.D.	William J. Romanos Jr., M.D.
James E. Deming	Lees M. Schadel, M.D.
Pablo Enriquez, M.D.	Frederick W. Schert, M.D.
Robert F. Feltman, M.D.	Guy T. Selander, M.D.
Richard Feinstein, M.D.	Roberto A. Sosa, M.D.
Lawrence M. Fishman, M.D.	John Stone, M.D.
Allan L. Goldman, M.D.	Robert H. Threlkel, M.D.
Henry L. Harrell, M.D.	Benjamin E. Victorica, M.D.
Allan Herskowitz, M.D.	Thomas M. Wiley, M.D.
James T. Howell, M.D.	Charles D. Williams, M.D.
Rubin Klein, M.D.	Frederic C. Wurtzel, M.D.
Karl J. Kramer, M.D.	

Subscription Rate: \$15.00 per year, single copy. \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917: authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

Scientific Articles

- 425 Management of Acute Myocardial Infarction
Louis Lemberg, M.D.
- 431 Gynecological Microsurgery in a Community Hospital
John J. Fisher, M.D.
- 434 Dysphagia and Cricopharyngeal Myotomy
George L. Kullman, M.D.
- 438 Successful Repair of Interventricular Septal Defect Resulting From Blunt Chest Trauma
Shaik A. Khuddus, M.D., et al

Special Articles

- 441 The Florida Statewide Health Coordinating Council—What Is It?
Emmet F. Ferguson, M.D.
- 443 Practicing Physicians, Past-Present-Future
Kenneth E. Penrod, Ph.D.
- 447 Preventive Medicine, A New Perspective
Martin L. Schulkind, M.D.

Editorials

- 416 Editorial Policies and Practices
Daniel B. Nunn, M.D.
- 416 Reflections On Book Reviews
F. Norman Vickers, M.D.

Organization

- 454 105th President of FMA, Sanford A. Mullen, M.D.
Clyde M. Collins, M.D.
- 454 Acknowledgement

Departments

- 413 President's Page
Community Service by Physicians
Sanford A. Mullen, M.D.
- 458 Medical News Around the State
- 463 Book Reviews
- 465 Meetings
- 467 Classified Advertising
- 470 Index to Advertisers
- 470 FMA Officers and Council Chairmen

Cover

Sanford A. Mullen, M.D., of Jacksonville, 105th President of the Florida Medical Association.

**REINSURANCE
BROKERS for
Florida Physicians
Insurance Reciprocal
—serving physicians
throughout Florida**



**The
Wetzel
Company,
Inc.**

P.O. Box 66452 · Houston, Texas 77006

Eliminate pinworm without dosage calculations

Compare:
Vermox[®] vs Antiminth^{*} and Povan[†]

	Patient Weight						
	40 lb	60 lb	80 lb	130 lb	150 lb	180 lb	200 lb
VERMOX	1 tab	1 tab	1 tab	1 tab	1 tab	1 tab	1 tab
Antiminth	4 ml	6 ml	8 ml	13 ml	15 ml	18 ml	20 ml [‡]
Povan tablets	2 tabs	3 tabs	4 tabs	6 tabs	7 tabs [‡]	7 tabs	7 tabs

[‡]Maximum dosage

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the

treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The VERMOX tablet may be chewed, swallowed or crushed and mixed with food. For control of pinworm (enterobiasis) a single tablet is administered orally, one time. If patient is not cured three weeks after treatment, a second course of treatment is advised.

Registered trademark of Raerig.

[†] Registered trademark of Parke-Davis.

Because VERMOX has not been extensively studied in children under two years of age, the relative benefit/risk should be considered before treating these children. VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug



Rx

*Vermox
Tabs #4
Sig 1 tab
each family
member*

Just one tablet eliminates pinworm, regardless of patient age^{††} and weight.

Vermox[®] CHEWABLE
TABLETS
(mebendazole)



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done



works well in your office...

NEOSPORIN® Ointment (polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



President's Page

Community Service by Physicians

On May 4, 1981, it was my honor to be installed as President of the Florida Medical Association. Each member of the FMA can be assured that I will do my very best to carry out the responsibilities of this important position. Together with the officers, Board of Governors, council and committee members and the professional staff, it is my hope that we will be able to carry on the outstanding tradition of my predecessors in this important position.

In my first official President's Page I would like to present to you my theme for the FMA year while I am President. That theme is "Community Service by Physicians." This theme will emphasize the need for physicians to become involved in all of the important affairs of their own communities.

Physicians occupy an extremely important position in their home communities. Almost as soon as they start practice they are socially recognized, are offered leadership roles in the community and are almost always assured of financial success. It sometimes becomes difficult for physicians to realize that these accolades are not granted simply because they have been fortunate enough to be accepted in medical school, complete the course of education and receive an M.D. degree and later receive advanced training in the medical field of their personal interest. The reason for this community recognition so early in the careers of physicians is due to the fact that their predecessors achieved prominence by their community service as well as by their professional skills.

Even though the medical profession has been attacked on all sides by various individuals and special interest groups, the physician remains the most respected member of our current day society. Many of the detractors of physicians are from groups which are considered by the general public to be much less worthy than the physicians they deride.

It should also be pointed out that most families are delighted to have a son or daughter who becomes a physician. Most physicians are fully aware of the difficulties of being accepted in medical school these days with only the brightest and most promising of our young men and

women accepted.

All physicians can attest to the fact that the long period of training and the relatively short period of practice make medicine the wrong field for any one who is interested primarily in financial achievement. There is no doubt that most physicians are involved in the practice of medicine because of a genuine desire to serve our fellow man.

It is this concept of service to our fellowman that I would emphasize in my theme for the year. My premise is that it is not enough to be a physician practicing at the highest standards of professional competence. This excellence of medical performance must never be compromised but physicians must not limit themselves solely to their professional activities.

Physicians must become involved in the important affairs of our community so that they will take part in the development of all worthwhile community activities. The type and degree of involvement by each physician will depend on his or her interest. Churches and synagogues, civic clubs, the Chamber of Commerce, arts groups, youth organizations, voluntary health agencies, charitable organizations, governmental bodies, and other groups literally cry out for physician involvement. The scientific and disciplined attitude and the emotional maturity of physicians make them ideal in all of these activities. The physician should be as the yeast in bread and permeate widely through all worthwhile community activities.

In closing I would emphasize that physician involvement in community affairs is not a one-way arrangement. By active work in the community, the physician benefits greatly by going beyond the often restrictive limits of the field of medicine. The opportunity to meet and exchange ideas with individuals from fields other than medicine provides great enrichment to the lives of physicians. In community service by physicians both the community and the physician are benefited. I urge that each FMA member become actively involved in his or her community.

Sanford A. Pullen, M.D.



THE COMPLETE INVESTMENT PORTFOLIO INCLUDES RARE COINS.

Rare coins can be an extremely rewarding way to diversify your investment portfolio. Quality U.S. rare coins provide a stable inflation hedge and have appreciated over the last decade at a rate averaging over 57% annually. Coin investing is the smart, sophisticated, and highly profitable way to complete your investment portfolio.

If you've been considering rare coins, you need professional guidance and expert advice. We are one of the largest firms in the country specializing in quality United States Rare Coins. We can also assist you in establishing coin funded Keogh, IRA, or Corporate Retirement Plans.

Serious inquiries invited.

(305) 373-3001

By appointment only.



**NUMISMATIC
INVESTMENTS
OF FLORIDA**

Brickell Center, Suite 701
799 Brickell Plaza
Miami, Florida 33131

Members:
Professional Numismatists Guild
& American Numismatic Association

CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacterio. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment of least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age. Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
<i>Respiratory Tract</i>		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

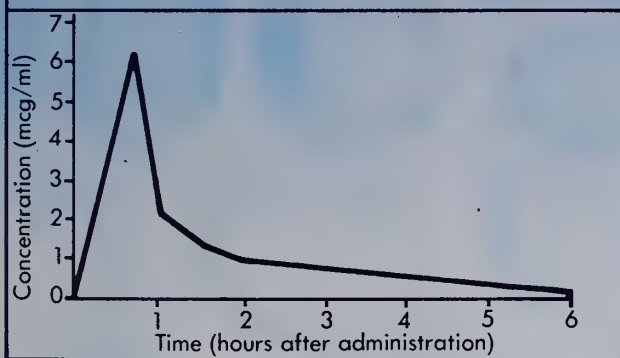
†depending on severity

Wyeth Laboratories
Philadelphia, Pa 19101

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes* for ampicillin.*



Mean blood levels in mcg/ml after 250 mg
cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T₀ ½ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Wyeth Laboratories • Philadelphia, Pa. 19101



Fewer episodes of diarrhea and rash
than with ampicillin in studies to date.

Efficacy proven in the treatment
of bronchitis, pneumonia, and upper
respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per
5 ml Suspension

more than just spectrum

NEW
NAME

Editorial Policies and Practices

The completion of my first year as Editor seems an appropriate time to review current editorial policies and practices with respect to material submitted for publication. In this manner, I would hope to answer queries about the type of material of interest to *The Journal*, who may submit material, and the editorial review process utilized to evaluate manuscripts.

As the official publication of a broad based organization with almost 14,000 members, *The Journal* necessarily assumes a multifaceted role. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Specifically, the Editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine. Although the Editors are especially inter-

ested in procuring material from FMA members, we are pleased to consider suitable papers written by other physicians or non-medical personnel. All material submitted should be prepared in accordance with the "Instructions for Authors" section of *The Journal*, printed on a semi-annual basis.

Manuscripts under consideration are subjected to review by at least two physician consultants in the proper discipline, one or more associate or assistant editors, and the Editor. When there is a question concerning either FMA policy or a potential legal problem, consultation is obtained with the FMA President, the executive staff, and legal counsel. After discussion by the Editorial Board, final decisions are made with the intent of selecting material which is new or current, well-written, accurate, and of sufficient interest and importance to the FMA membership.

Daniel B. Nunn, M.D.
Editor

Reflections on Book Reviews

Readers frequently ask *The Journal* about the process by which books are selected for review and about how reviewers are chosen. *The Journal* and the book review editor strive to select medical books which we think will be of general interest to our readers, leaving books on more esoteric subjects to more highly specialized technical journals. Occasionally, we feel that a

review of books of general, rather than strictly medical, interest should be included in these pages. We hope that each physician, and sometimes the family of that physician may find our pages of interest. This philosophy is consistent with our policy of publishing an Auxiliary issue annually, of interest to the physician and his family.

The thoughtful essay by Dr. Pascal James Imperato

in the August 1980 issue of the "*Forum of Medicine*", a medical monthly formerly published by the American College of Physicians, covers the subject of reviewing of medical books quite well.

The book reviewer should have knowledge of the subject under review and the ability to express balanced judgment on that book. Our reviewers, of course, review these books without remuneration. The delima of the book review editor is to avoid reviewer fatigue by calling on his tried and true reviewers too often. The problem, on the other hand, is discovering new reviewers with interest and qualifications of a good reviewer.

Occasionally, reviewers who have clear cut conflict of interest are inadvertently requested to review a book. If so, they should disqualify themselves. They may have written a book covering the same subject matter for the same audience. A book, so reviewed, could hardly expect to be given an impartial judgment. On the other hand, rave reviews written by friends may suffer significant bias, also.

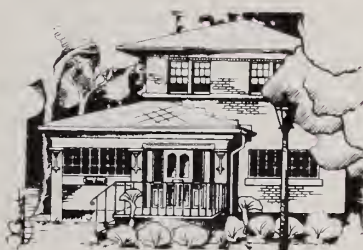
Our readers face a responsibility, also. We encourage letters to the Editor expressing disagreements to book reviews. This would let the Editor as well as future reviewers know that their opinions are subject to criticism. The book review editor pledges to you, the reader, that he will exercise judgment on each review to assure,

as best he can, that reviews are balanced and fair.

In the past, books listed in the "Books Received" column were available for review on request. Difficulties arose, occasionally, when they were requested by physicians who had no special qualifications in the area of the subject of the book. Now, *The Journal* usually assigns books for review to avoid that complication. We would be pleased to consider a request to review a book on individual merit. We are pleased, also, to receive an unsolicited book review if the author of that review has special qualifications and submits a review which is judged to be of interest to a significant number of our readers. We occasionally get requests from medical students for books to review. We usually meet this challenge by asking the medical student to obtain permission from his professor to co-author that review. This gives the reader and the book review editor assurance that critical review has been passed on the subject matter.

Finally, we should remember that book reviews usually represent one person's opinion and that sometimes the opinion reveals more about the reviewer than it does about the book.

F. Norman Vickers, M.D.
Book Review Editor
Pensacola



THE HOT SUN, A COOL BREEZE AND FLORIDA SEAFOOD

Summertime's Finest

What finer combination? Right now is the time to order Florida's Finest Seafood, fresh from the Atlantic and Gulf, to you or your friends.

This seafood is Flash Frozen to ensure freshness, and ready for immediate heating and serving. We've done the preparation, all you have to do is thaw, and heat, and then sit back and listen to the raves.

Lobster Thermidor, Florida Lobster, Stone Crab Claws, Shore Dinners, Pompano Papillote, Swordfish Steaks — all of these delicious treats await you and your guests for the asking.

And, for the first time, our **Rare Jumbo Shrimp**. These spectacular Jumbo's are peeled and deveined, ready for cooking and eating. These beauties are over 4 inches long, and the taste is mouth-watering! (3# — \$59.75; 6# — \$89.75). This is **pure shrimp, no shells — 100% edible** — ready to boil, steam or fry.

REMEMBER — these Florida Delicacies are available all year long — but, summertime is seafood time.

Healthful, Delicious and Low Calorie! The Perfect Combination! Surprise your family and friends with **FLORIDA'S FINEST SEAFOOD**.

Use this handy order form below, or contact your local Chairman or President, or write:

Mrs. David Whittaker
Florida Medical Association Auxiliary
1140 S.E. Fort King Street
Ocala, Florida 32670
(904) 622-6605

Benefits go to the Florida Medical Association. Make checks payable to "FMA-Auxiliary — FMF".

All orders arrive in our own styrofoam container, which can be used again and again. All products are unconditionally guaranteed.

Name: _____

Address: _____

Phone No.: _____

Item Ordered: _____ Cost: _____

Brochure Requested: ☐

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid over-sedation. Terminate dosage gradually since abrupt withdrawal of any anti-anxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chloridiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan[®]
for (lorazepam)
Anxiety

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; Insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.



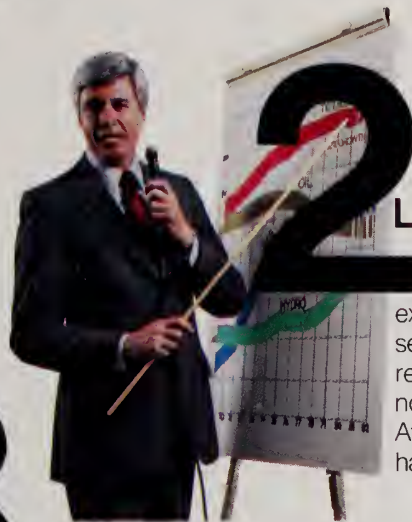
Four practical reasons to prescribe **Ativan[®]** **for** (lorazepam) **Anxiety^{*}**



1

No interaction with more than 300 drugs[†]

In clinical studies, Ativan was given concomitantly with hundreds of medications, including gastrointestinal and cardiovascular, with no reported interactions. Whereas the interaction of diazepam and cimetidine has been shown to cause increased sedation in patients taking both drugs, the clearance of Ativan is not delayed by Tagamet.[‡]



2

Lets most patients stay active

Long-acting benzodiazepines have long-acting metabolites with activity which can produce excessive accumulation that may lead to unwanted sedation. Ativan[®] has no active metabolites, reaches steady state in 2 to 3 days and usually does not cause oversedation. Also, the shorter half-life of Ativan is consistent with b.i.d. dosage, so drug hangover is seldom a problem the next morning.



3

Not appreciably affected by aging

Unlike the long-acting benzodiazepines—diazepam [®], chlordiazepoxide [®], clorazepate [®] and prazepam [®]—the metabolism and clearance of Ativan are not appreciably affected by the aging process.



4

Not significantly affected by liver dysfunction

Ativan[®] is metabolized in one simple step to an inactive glucuronide; its absorption and excretion are not significantly altered by cirrhosis or hepatitis. By contrast, the metabolism of diazepam and chlordiazepoxide has been reported to be significantly altered in patients with liver dysfunction.

^{*} Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic.

[†] All benzodiazepines, however, produce additive effects when given with CNS depressants, such as barbiturates or alcohol.

[‡] Tagamet (cimetidine) is a registered trademark of Smith Kline & French Laboratories, Division of SmithKline Corporation.

Copyright © 1981, Wyeth Laboratories. All rights reserved.

Wyeth Laboratories
Philadelphia, PA 19101



TM

DRAMATIC NEW CLINICAL PROOF*

In the treatment of impetigo—

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**



As seen on admission



After one week of penicillin V-K therapy



Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. No treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular.

(12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but no failures with Tegopen.

		Given Tegopen® (cloxacillin sodium)	Given penicillin V-K
<i>Staphylococcus aureus</i>	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
<i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i>	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic <i>Streptococcus</i>	(1 patient)	0	1
TOTALS:	102 patients	52 patients	50 patients

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported

the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus*, 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes*, and 1% beta-hemolytic *Streptococcus*.†
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.

- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

†The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®

(cloxacillin sodium)

-effective therapy for staph infections of the skin and skin structures

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose

stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q. 6h.

Children: 50 mg./Kg./day in equally divided doses q. 6h. Children weighing more than 20 Kg should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®

Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201

Copyright © 1981, Bristol Laboratories

**When you need
a lot of money,
DAC and your
house may be
the best friends
you have.**



As a physician, cash flow and large dollar requirements can sometimes be a problem. Probably one of your biggest assets and surest means of obtaining large cash sums is your home equity.

Let DAC show you how simple it can be to arrange a home equity loan. Loans are available for up to \$50,000 or more with terms up to 12 years.

So, if you need cash for setting up or expanding a practice, new equipment, business investments, major purchases, etc., call your nearest DAC office — there are 13 in Florida!

Licensed Mortgage Broker

DAC
Corp. of Fla.

An affiliate of The Old Stone Bank

MICROSURGERY COURSES

The Microsurgery Laboratory at the University of Florida offers three and five day courses aimed at teaching techniques applicable to:

Extracranial to Intracranial Bypass
Digital Reimplantation
Tubal Reanastomosis
Vasovasostomy
Transsphenoidal Surgery
Temporal Bone Dissection
Other Microsurgical Operations

For Information write:

Mrs. Cindy Brady
Microsurgery Laboratory
Box J265
University of Florida Health Center
Gainesville, FL 32610

Familial Ovarian Cancer Registry



There are increasing reports of ovarian cancer occurring in two (2) or more family members. The Familial Ovarian Cancer Registry will evaluate this increase to obtain information for genetic counseling to family members. Case accrual will evaluate:

- the number of cases of familial ovarian cancer
- the type of inheritance
- the relationship to breast and endometrial carcinoma
- the study of environmental, geographical and racial factors
- genetic counseling.

Please address inquiries regarding the clinical history of any family with two (2) or more members with ovarian cancer to:

Familial Ovarian Cancer Registry
M. Steven Piver, MD • Roswell Park Memorial Institute
New York State Department of Health • 666 Elm Street
Buffalo, New York 14263
Telephone: (716) 845-3110

Professionals Helping Professionals For Over 20 Years

Bradenton
6221 14th St. West
756-9575

Clearwater
2280 U.S. Highway 19 N.
796-2587

Daytona Beach
2040 S. Ridgewood Ave.
761-8500

Ft. Lauderdale
1771 N. W. 40th Ave.
735-5111

Jacksonville
3986 Boulevard Center Dr.
396-9496

Lakeland
402 S. Kentucky Ave.
687-2533

Melbourne
17 E. Hibiscus Blvd.
727-3510

Ocala
2945 N. E. 3rd St.
732-4336

Orlando
3438 Lawton Rd.
894-3711

Pensacola
5150 Bayou Blvd.
478-3215

Tallahassee
2574 Seagate Dr.
878-3149

Tampa
402 Reo St.
879-3181

West Palm Beach 2240 Palm Beach Lakes Rd. 689-0080

PAIN AND TENSION...

Double fault for weekend warriors

ACE THE ACHE
with

Equagesic[®] IV

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

“Possibly effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a “crutch” may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use

of minor tranquilizers (meprobamate, chloridiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug. Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery. Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow CNS stimulants, e.g. caffeine, Meclazol or amphet-

mine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions. Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases observed only very rarely may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted. Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug. Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright © 1981, Wyeth Laboratories
All rights reserved.

*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, PA 19101





Down with pain

Step up to reliable relief

for mild to moderate pain

Wygesic[®] IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine, although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see Warnings). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported. Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analgesic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information (JAMA 237 2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

Copyright © 1981, Wyeth Laboratories.
All rights reserved.

Wyeth Laboratories
Philadelphia, PA 19101



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

JUNE 1981
VOL 68 • NO. 6

Management of Acute Myocardial Infarction

Louis Lemberg, M.D.

Abstract: Detailed clinical observations and monitoring of acute cardiac patients made possible with the advent of coronary care units have resulted in changes in old and fixed concepts of management and the establishment of newer ones.

This article presents the author's approach to the management of acute myocardial infarction in the uncomplicated and complicated patient. Prevention and prompt treatment of complications, and preservation of ischemic myocardium are major goals in therapy. The experimental uses of glucose-insulin-potassium and more recently intravenous propranolol are discussed.

It is estimated that 1½ million episodes of acute myocardial infarction (AMI) occur each year in the United States.¹ In the precoronary care unit era, one third of those who were hospitalized succumbed to their illness. This mortality rate has been reduced by 50% with the advent of the CCU.² Nevertheless, AMI remains the most common cause of hospital deaths in the United States.

This presentation outlines the routine management of AMI and the treatment of the principal complications.

Routine Management

Prompt Admission to a CCU

Cardiac arrest or serious arrhythmias are very common in the early hours of an AMI. Sixty percent of the deaths associated with AMI occur within the first hour after its onset. Patients with suspect or AMI should be promptly transferred to a CCU by a telemetry-equipped ambulance that has oxygen, DC defibrillator and commonly used cardiac drugs.

The Author

LOUIS LEMBERG, M.D.

Dr. Lemberg is from the Division of Cardiology, Department of Medicine, University of Miami School of Medicine, Miami.

Supported in part by a grant from Mr. Ad Miller.

Bed Rest

The routine 6-8 weeks of strict bed rest for all AMI patients was challenged in 1952 by Levine who first advocated the chair treatment for AMI.³ Currently, sitting in a bedside chair can be allowed in most patients on the second day of coronary care and the use of a bedside commode from the time of admission. Ambulation in the uncomplicated case can be started as early as the fourth day; telemetry monitoring in a step down unit can begin on the fifth day and the patient can be discharged from the hospital on the seventh to ninth day.

When in bed, the patient should be in a half sitting position with the head of the bed elevated at around 30°. This position helps to lower central volume and thus decreases cardiac work.

Analgesics

Prompt alleviation of pain is imperative. Morphine 2.5 to 3 mg intravenously is highly effective in the majority of patients. Titration of 1 to 2 mg doses may be required until analgesia or sedation are achieved. Adverse reaction such as nausea and hypotension are rare with these low doses.

Nitroglycerin sublingually is useful for recurrent ischemic pain following AMI. A hypotensive response to nitroglycerin is unusual when the patient is in bed. However, a hypotensive reaction can be readily reversed by

transient elevation of the legs.

Oxygen

Low flow O₂ therapy at 5 liters/minute by nasal prongs is routine and has proven to be effective therapy. Patients with AMI, even when uncomplicated, are frequently hypoxemic on room air.

Sedation

Judicious use of sedation or tranquilizers as a supplement to calm and confident reassurance decreases the risk of ventricular arrhythmias and helps to limit infarct size. Psychological strain may increase the risk of ventricular arrhythmias in AMI.

Anticoagulants

Anticoagulation is no longer routine in the management of AMI. Early chair treatment and ambulation has all but eliminated deep vein thrombosis. Only those with serious peripheral vascular disease or significant leg edema require anticoagulation.

Diet

Patients with AMI should not be stressed with foods which require chewing. Liquids such as fat free milk and juices are adequate for the first 24 to 72 hours. Subsequent changes in diet should be limited in calories and salt content.

Complications of AMI

During the first 48-72 hours of AMI some form of irregularity of the heart beat is exhibited in more than 95% of patients.

Ventricular Premature Beats (VPBs) predispose to ventricular tachycardia (VT) and ventricular fibrillation (VF) in AMI. The "warning" arrhythmias first identified by Lown, et al as requiring prompt antiarrhythmic therapy (5 VPBs/min, multifocal VPBs, 2 VPBs in a row, R-on-T phenomenon) actually occur in only 60% of patients in whom VF develops. Furthermore, half of the patients with "warning" arrhythmias do not develop VT or VF.⁴ In AMI a VPB falling anywhere in the cardiac cycle may cause VT or VF.

Lidocaine 200 mg intravenously given in divided doses during the first 15 minutes and followed by a continuous infusion of 2-4 mg/min usually stops the "warning" arrhythmias. However, in the CCU with alert personnel a continuous infusion of lidocaine is probably unnecessary as a routine procedure. Prior to hospitalization 300 mg of lidocaine given intramuscularly may be effective as a prophylactic measure.

Ventricular premature beats that are unresponsive

to lidocaine in the early hours following AMI, especially in the presence of sinus tachycardia, may respond to intravenous propranolol 0.5 mg every 2 minutes up to a total of 6 mg.

When VPBs persist or if they cause hemodynamic compromise or when there is recurrent VT or ventricular fibrillation despite lidocaine therapy, oral administration of quinidine sulfate with a loading dose of 450-600 mg followed by 200-400 mg every 6 hours may be effective.

Procainamide can be used as an alternative to quinidine sulfate. Five hundred to 1,000 mg are given orally as a loading dose followed by 250-500 mg every four hours. Plasma concentrations can be followed to insure adequate therapeutic levels in resistant cases.

Disopyramide phosphate (Norpace) in AMI is undesirable because of its depressant effect on cardiac function and anticholinergic action.

Sustained Ventricular Tachycardia should be promptly abolished using DC countershock. Generally low energies in the range of 10-25 joules are effective. Striking a sharp blow to the precordium (thump version) may at times be successful and is worth trying prior to electrical countershock.

Ventricular Fibrillation during the first few days of AMI when treated promptly with electrical countershock does not affect prognosis adversely.

The *Bradyarrhythmias* (sinus bradycardia, AV conduction defect, junctional rhythm) generally have a good prognosis and do not require intervention unless the slow rate enhances the frequency of VPBs or causes symptoms and signs of impaired peripheral perfusion due to a reduced minute volume (the quantity of blood ejected by the heart each minute).

Accelerated idioventricular rhythm is a ventricular rhythm with a rate usually between 60-100/minute and occurs in 30% of patients with an inferior MI. Two forms are seen with equal incidence: Type I and Type II. In Type I, the idioventricular rhythm usually starts and ends with a fusion beat and remains regular. In Type II, the arrhythmia is initiated with a premature beat and the rate starts at 60-100/minute but accelerates to 130 or more, often ending with a compensatory pause and at times with VT or VF. Type I is benign, transient, causes no symptoms and does not require therapy. Type II requires the usual antiarrhythmic treatment used for VPBs since VT and VF can result with this form.

In acute inferior MI, 1° AV block and 2° AV block of the Wenckebach type or even some cases of complete block in the AV node do not require therapy. The critical factor in management is the ventricular rate. No treatment is necessary if a slow rate does not cause symptomatic hypotension or enhance the appearance of VPBs. Block in the AV node usually results in a subsidiary pacemaker appearing in the junctional tissues where the

inherent rate is between 40 and 60 beat/minute a range that is generally adequate for maintaining a stable hemodynamic state in a recumbent position. Atrioventricular block is often transient in acute inferior MI and if symptoms are borderline or mild, elevating the legs for a short time may be all that is needed in order to maintain perfusion to vital areas.

In symptomatic patients atropine sulfate 0.4 mg IV is given and repeated every 2 minutes up to 2 mg or until an adequate heart rate is achieved. Isoproterenol can be helpful if atropine is ineffective. An infusion of 1.0 mg in 500 cc D/W is titrated to attain an appropriate rate. Isoproterenol increases oxygen consumption; however, if its use results in an improvement in AV conduction and heart rate, then the increase in oxygen consumption is more than balanced by the improvement in cardiac rhythm. Temporary pacing is initiated if drug therapy is not tolerated or ineffective. Permanent pacing is rarely necessary because the AV node recovers its function in almost all cases if at least three weeks are allowed before a decision for permanent pacing is made.

Acute bifascicular block, i.e. RBBB with left superior or inferior divisional block, is usually associated with an extensive anteroseptal infarction and requires temporary insertion of a demand pacemaker. Acute persistent RBBB and RBBB alternating with LBBB also require temporary insertion of a pacing catheter, because these and acute bifascicular block have a high incidence of progression to complete AV block (30% to 50%). The subsidiary pacemaker in complete AV block due to trifascicular disease is located in the Purkinje fibers of the LV where the inherent ventricular escape rate is 25 to 40 beats/minute. These slow rates are inadequate for normal peripheral demands. Those who develop complete trifascicular block have a high mortality (85%). A permanent demand pacemaker should be implanted prior to hospital discharge in survivors of acute transient or permanent trifascicular block.

Atrial Premature Beats are benign and do not require treatment. However, they often are harbingers of atrial tachycardia, atrial flutter, or atrial fibrillation. When atrial flutter or atrial fibrillation occurs in inferior MI the ventricular response rate is generally not excessive and therefore tolerated. This is because AV nodal injury often accompanies an acute inferior MI resulting in prolonged AV transmission which can be occult but be exposed by rapid atrial rates. When atrial flutter or atrial fibrillation complicates an anterior infarction, the ventricular response rate is usually rapid. The prime consideration in therapy is the ventricular rate. When the ventricular rate is greater than 120 and there is a loss of atrial transport the following adverse effects occur: hypotension, increased cardiac work and oxygen demand, decreased perfusion of the coronary bed, and progressive worsen-

ing of congestive heart failure. Therefore, there is an urgent need to slow the ventricular rate and restore atrial contribution to ventricular output by establishing sinus rhythm.

The success in achieving prompt slowing of the ventricular response to atrial fibrillation or flutter with the use of digitalis alone is unpredictable. Furthermore, the enhanced danger of digitalis toxicity in AMI where the myocardium may be more sensitive to the glycosides dictates caution and prevents its use in amounts required to achieve an early decrease in the ventricular rate. In the interest of preserving injured myocardium and limiting infarct size, prompt reduction of ventricular rate with attempts at conversion to sinus rhythm is imperative. Electrical cardioversion is only transiently effective because in this clinical setting atrial fibrillation often recurs after a brief period of sinus rhythm. Propranolol 0.5 mg given IV every 2 minutes up to 10 mg (average 5 mg) is effective in controlling the rapid ventricular rate and frequently converts the atrial fibrillation to sinus rhythm within five to 15 minutes.⁵ As a result, prompt subjective and objective improvement occurs. Heart failure, commonly associated with atrial arrhythmias, responds more readily to diuretics or vasodilator therapy following resumption of sinus rhythm or when the ventricular rate is controlled.

The electrocardiogram should be monitored during IV propranolol administration; atropine sulfate and isoproterenol should be at hand to counteract an excessive slowing of the heart rate.

Congestive Heart Failure

Congestive heart failure (CHF) complicates AMI in 50% to 60% of patients. In many, the clinical findings of CHF are not overt and a diagnosis depends on a meticulous search for rales and a pathologic S3 gallop.

The efficacy of digitalis in the management of CHF complicating AMI has not been established; the hemodynamic response to digitalis in this clinical setting is unpredictable. Thus, major reliance should be placed on diuretic or vasodilator therapy.

In mild CHF, only diuretics are required. The urine output is a prompt measure of a response and serves as a simple guide to therapy. Symptomatic improvement frequently parallels and adequate diuresis; the resolution of pulmonary rales, however, has a short lag time. The use of diuretics entails little risk as long as there is awareness that hypovolemia and electrolyte imbalance are potential complications. The beneficial effects of furosemide in relieving pulmonary congestion in patients with left ventricular failure complicating AMI are due to two actions. Initially IV furosemide causes, within five to 15 minutes, a decrease in left ventricular filling pressure as a conse-

quence of an increase in capacity of the peripheral veins. This is followed by diuresis with a peak increase in urinary flow at 30 minutes and a further decrease in left ventricular filling pressure.⁶

With severe degrees of heart failure both diuretics and vasodilators are used. Added benefits to the treatment of CHF are derived from the vasodilating drugs. Diuretics reduce fluid volume in the vascular bed and vasodilators increase the capacity of the vascular bed; the combination has additive effects on lowering preload and afterload.⁷ Nitrates sublingually or in an ointment base are effective vasodilators and simple to use.

When manipulating intravascular fluid volume with diuretics, or the capacity of the vascular bed with vasodilators, hemodynamic monitoring may be necessary. Intravenous vasodilators such as nitroprusside and nitroglycerin require monitoring using a flow directed balloon tipped catheter for pulmonary capillary wedge pressure determinations and an arterial line for direct arterial pressure because their onset of action is rapid and the duration of effect short.

Nitroglycerin infusion is useful in the management of intractable angina as well as severe heart failure. Continuous infusions are started at 10 ug/min and increased by 5 ug/min every 5 minutes.

Nitroprusside is infused at doses ranging from 20 to 200 micrograms/minute. The endpoint for nitroprusside or nitroglycerin infusion is a lower left ventricular end diastolic pressure, usually about 15 mg Hg or less providing arterial pressure or peripheral perfusion is not compromised. Left ventricular end diastolic pressures are determined by measurements of pulmonary capillary wedge or pulmonary artery diastolic pressures. Thiocyanate, a toxic metabolite, can accumulate after 48 hours of nitroprusside administration and cause headaches, blurring of vision, nausea and central nervous system depression. Serum levels of thiocyanate should be measured after two days of therapy and not allowed to exceed 6 mg/100 ml. Prompt improvement occurs when the infusion is discontinued.

Cardiogenic Shock

Shock is a hypotensive state accompanied by clinical signs of poor peripheral perfusion, that is, cool or clammy skin, poor mentation and a reduced urinary output. Lactic acidosis, a complication of shock, is produced as a result of tissue hypoxia and anaerobic metabolism. When shock complicates AMI, it is best to consider cardiogenic shock last. Hypovolemia and arrhythmias should be thought of first as possible causes of shock during AMI because these occur more frequently and can be corrected whereas cardiogenic shock is infrequent and difficult to reverse.

In all forms of shock, shifts of volume occur within

the vascular space as a result of compensatory responses to hypoxia and hypotension. Various states of vascular constriction and dilation occur in the organ systems, the degree of which is determined by the integrity of the arterial supply to the organs. Blood flow is redistributed so that vital organs (heart, brain and kidneys) receive a greater proportion of blood at the expense of nonvital areas. Constant monitoring of circulatory volume and fluid balance is therefore paramount in all forms of shock in order to maintain an adequate fluid volume.

Hypovolemia, a frequent cause of shock, can be due to a reduction in total circulatory volume or to a decrease in the effective circulatory volume. A decrease in the effective circulating volume can result from either sequestration of fluid in one or more of the vascular compartments where alterations in venous, capillary, or arterial tone have occurred, or from a shift of fluid into interstitial tissues.

Hypovolemia is confirmed by hemodynamic monitoring. A hypotensive state with a pulmonary capillary wedge pressure less than 15 mg Hg requires a fluid challenge for volume expansion. Dextran 40 or reconstituted serum albumin is infused to raise the pulmonary wedge pressure to 15 to 18 mg Hg in order to achieve an appropriate blood pressure response. Saline may be used but requires more attention to changes in intravascular volume and pressure.

Marked tachyarrhythmias or bradyarrhythmias that are responsible for a significant reduction in cardiac output can produce shock. The hypotension is a direct consequence of a critically reduced minute volume. Arrhythmias that contribute to the hypotensive state can be readily recognized and should be treated promptly.

When arrhythmias and hypovolemia have been ruled out as possible causes of hypotension, then cardiogenic shock is considered. The implications are that 40% or more of the myocardium is either necrotic or severely injured, causing major impairment in myocardial contractility. Norepinephrine can be used initially to support arterial pressures and thus improve coronary blood flow. However, norepinephrine may increase oxygen consumption by enhancing afterload and stimulating contractility, but if therapeutic blood pressure levels are attained, benefits derived from improved coronary perfusion outweigh the slight increase in oxygen consumption. In this way norepinephrine may help stabilize a profoundly hypotensive patient during the time it takes to establish appropriate hemodynamic monitoring. Severely injured myocardium is in a precarious state of survival and any potential for recovery is time dependent. Low dose norepinephrine 4 to 8 mg in 1,000/L of 5% D/W is titrated to raise the systolic pressure to 85 to 100 mg Hg.

Dopamine may be preferred in cardiogenic shock with mild hypotension and has the advantage of selective

vasoactivity. At low doses, dopamine increases cardiac output and selectively dilates the renal and mesenteric arterioles. At higher doses dopamine causes vasoconstriction and may overwhelm any vasodilator effects on the renal and mesenteric vessels.

Patients who fail to respond rapidly to drug therapy have a good chance of being stabilized, at least temporarily, by insertion of an intra-aortic balloon pump (IABP). There is no other intervention that can support systemic arterial circulation while simultaneously decreasing myocardial oxygen demands by afterload reduction. The cardiovascular surgery team that initiates and operates the IABP should be alerted early when pharmacological stabilization is attempted in order to minimize the critical time between drug therapy and use of the IABP, should the former fail. Patients with significant peripheral vascular disease are not suitable candidates for the IABP.

The mortality among cardiogenic shock patients remains very high regardless of therapy. The best efforts, therefore, relate to prophylactic measures, i.e. therapy aimed at reduction of infarct size. Thus preservation of ischemic myocardium by measures that reduce cardiac work and promptly control complications will favorably influence the incidence of CHF, cardiogenic shock and the ventricular arrhythmias.

Right Ventricular Infarction

Right ventricular infarction has only recently been recognized clinically as being a site of major damage. It is always associated with acute inferior MI because the posterior wall of the right ventricle and the inferior wall of the left ventricle have a common blood supply.

Right ventricular infarction should thus be a consideration in all cases of acute inferior MI when the following features are present: (1) an elevated systemic venous pressure; (2) a low cardiac output; and (3) absence of pulmonary edema. Bedside echocardiography will help to rule out cardiac tamponade.⁸ Hemodynamic monitoring is necessary for diagnosis and treatment.

Management is directed at volume expansion to correct symptomatic hypotension and oliguria. In these cases the right ventricle is dilated, contracts very poorly, and is therefore thought to function as a passive conduit.

The Labile Blood Pressure

Elevated blood pressures are the rule in the early stages of AMI. Clinical observations, however, have shown that blood pressures are labile within the first 24 to 36 hours after the onset of AMI and that in fact, the majority will return to normal within six hours after the onset of AMI. Therefore, because of fluctuations in blood pressure that commonly occur during the early phase of

an AMI, the routine use of specific drug therapy during this period in order to manipulate arterial pressures is unwarranted and may be hazardous.

When pain and anxiety accompany an elevated blood pressure, prompt relief with intravenous morphine sulfate will frequently initiate a return to normotensive levels. If the blood pressure is still high after appropriate sedation or analgesia then the use of intravenous nitroprusside with hemodynamic monitoring is indicated. Long acting hypotensive drugs used in the early period of AMI may result in symptomatic hypotension when their prolonged effect coincides temporally with the natural fall in blood pressure that occurs during the first 24 hours.

A drop in blood pressure to hypotensive levels (i.e. systolic pressure of 80 to 100 mm Hg) that occurs in the first day or two as a natural sequence of events does not require intervention in the absence of clinical manifestations of shock. Close patient observation in order to detect changes in the clinical state is all that is necessary.

Pericarditis

Although acute pericarditis is a frequent complication of AMI, symptomatic pericarditis is infrequent. The pain of pericarditis usually responds to salicylates, codeine sulfate or indomethacin. In resistant cases, a short course of corticosteroids for one or two days is usually effective. Generally this complication does not alter prognosis.

Arrhythmias During Convalescence

Prior to hospital discharge a 24 hour ambulatory recording (Holter) of the electrocardiogram should be obtained. This will help in detecting any complex ventricular or atrial arrhythmias or significant ST segment depression. Arrhythmias that appear during convalescence are frequently related to varying degrees of CHF. This relationship has been verified by the finding of elevated left ventricular end diastolic pressures in the majority of these patients. Tighter control of failure, even when not overt, by a trial increase in the diuretic dose, or greater restriction of dietary sodium will often eliminate or reduce the frequency of the arrhythmias.

Low Level Treadmill Testing

Low level exercise testing can be safely performed two to three weeks after an AMI. The test yields objective data concerning cardiovascular performance that enable the physician to prescribe the level of physical activity for the patient. The test may also unmask angina, exertional hypotension, ischemia or arrhythmias not previously detected.

Preservation of Ischemic Myocardium

Almost every aspect of management in AMI is primarily aimed at reducing cardiac work and thus lowering myocardial O₂ consumption. Very little, if anything, can be done to improve O₂ delivery to the ischemia area. Since the preservation of ischemic myocardium is dependent on a favorable balance between O₂ supply and demand, measures that lower O₂ demands become vital in efforts to limit infarct size.

A number of therapeutic approaches aimed at reducing the extent of ischemic damage and preserving jeopardized myocardium are currently undergoing clinical trials. The following two appear most promising for the future.

Glucose-Insulin-Potassium

Recent reports have shown that a solution containing 300 g of glucose, 50 units of regular insulin and 80 mEq of potassium chloride in a liter of distilled water (GIK solution) infused via a central venous line at a rate averaging 100 ml/hr has been highly successful in limiting the extent of ischemic damage.⁹ The metabolic effects of this solution are the enhancement of carbohydrate utilization by the myocardium and suppression of elevated serum levels of potentially toxic free fatty acids. Overall mortality has been significantly reduced and ventricular arrhythmias suppressed. Glucose-insulin-potassium solution is most effective when used in the first four to six hours after the onset of AMI. The duration of therapy is 48 hours. Frequent serum potassium and glucose determinations are required. Insulin dosage is adjusted in diabetics. Patients with advanced renal disease are not candidates for therapy. Lidocaine, diuretics or vasodilators can be given concomitantly, if indicated. Although still experimental, this form of therapy shows promise.

Propranolol

The experimental use of propranolol within the first four hours of AMI has been reported to reduce ischemic injury and thus limit infarct size.^{10 11} The beta adrenergic blocking drugs protect the myocardium from the effects of high levels of circulating catecholamines that occur in AMI. In this way heart rate and contractility are decreased and, in effect, O₂ demands lowered.

Propranolol is administered intravenously 0.5 mg every 2 minutes for a total dose of 0.1 mg/kg. This is followed in one hour by 20 to 80 mg of oral propranolol every 6 hours during hospitalization. The usual precautions with propranolol use are followed. The method is still experimental but deserves attention.

References

1. Grace, W. J. and Keloun, V.: Coronary Care Unit, Appleton-Century-Crofts, New York, 1970, p. 1.
 2. Braunwald, E.: Heart Disease, Textbook of Cardiovascular Medicine, Saunders, 1980, p. 1354.
 3. Levine, S. A. and Lown, G.: Armchair Treatment of Acute Coronary Thrombosis, JAMA 148:1365, 1952.
 4. Lie, K. I.; Wellens, H. J. J.; Downar, E. and Durrer, D.: Observations on Patients with Primary Ventricular Fibrillation Complicating Acute Myocardial Infarction, Circulation 52:755, 1975.
 5. Lemberg, L.; Castellanos, A. Jr. and Arcebal, A. G.: Use of Propranolol in Arrhythmias Complicating Acute Myocardial Infarction, Am. Heart J. 80:479, 1970.
 6. Dikshit, K.; Vyden, J. K.; Forrester, J. S.; Chatterjee, K.; Prakash, R. and Swan, H. J. C.: Renal and Extrarenal Hemodynamic Effects of Furosemide in Congestive Heart Failure After Acute Myocardial Infarction, N. England J. Med. 288:1087, 1973.
 7. Lemberg, L.: Changing Concepts in Management of Congestive Heart Failure, J. Florida M. A. 65:415, 1978.
 8. Lorell, B., et al: Right Ventricular Infarction. Clinical Diagnosis and Differentiation from Cardiac Tamponade and Pericardial Constriction, Am. J. Cardiol. 43:465, 1979.
 9. Rogers, W. J., et al: Prospective Randomized Trial of Glucose-Insulin-Potassium in Acute Myocardial Infarction. Effects on Myocardial Oxygenation and Hemodynamics, Circulation 49:1078, 1974.
 10. Peter, T., et al: Reduction of Enzyme Levels by Propranolol After Acute Myocardial Infarction, Circulation 57:1091, 1978.
- Dr. Lemberg, Division of Cardiology (D-39), University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

Gynecological Microsurgery in a Community Hospital

John J. Fisher, M.D.

Abstract: A series of cases of infertility and subsequent microsurgery to correct the malfunction are reported. The cases involved tubes which had been closed either by previous disease, adhesions from previous surgery, or previous tubal ligation surgical procedures. In all cases, surgery succeeded in opening the tubes, and pregnancy was accomplished in 71% of the cases. Although traditionally performed in a teaching hospital setting, gynecological microsurgery is feasible by a private practitioner in a community hospital.

In an editorial appearing in *Modern Medicine* written just before his untimely death, Dr. Michael Halberstam decried the fact that although well over 90% of the medical care in this country is delivered "outside the purviews of a university hospital" almost all articles published in today's medical journals are from academic centers. He reiterates the observation that although medicine is taught in large universities, it is practiced in small offices.

Dr. Halberstam goes on to praise a recent issue of the *Surgical Clinics of North America*, unique in that the entire contents were original papers by practicing physicians in a small community. Embracing this encouragement, yet without university affiliation, I offer this report of my experiences in a would-be sacrosanct field of academic endeavor, namely microsurgery.

Originally the procedure of the otolaryngologist and ophthalmologist, microsurgery has recently been adopted by other specialties. In gynecology its greatest application is in the area of tubal reconstruction. There is a vast difference between the technical levels demanded by the suturing of the fine nerves and blood vessels involved in replantation work and the relatively gross diameter of the tubal lumen, minute as it may appear to the unaided eye. Certainly, the former requires special workshop training, perfection of new suture tying techniques, and constant practice to maintain dexterity. Such are hardly the sine qua non for obtaining successful results in tubal microsurgery.

On the other hand, I do not advocate that the average obstetric-gynecologic generalist feel that this surgery should be included in his repertoire. It is somewhat diffi-

cult to envision a physician coming from a night spent lending support to an anxious couple in a birthing room stepping into the surgical demands of a three hour reanastomosis procedure. The average doctor specializing in gynecology and truly surgically oriented, however, should have no difficulty in achieving acceptable results in microsurgery providing he has patience and an underlying respect for its principles. It is for the direct encouragement of the latter that this paper is written, and for the indirect purpose of bringing the advantages of this type surgery to those hundreds of thousands of women who do not have easy access to the large medical center.

Technique

The biggest step toward performance of microsurgery is adjustment to using the advantages offered by the operating microscope. Tubal surgery can quite easily be accomplished at six to ten power magnification. Whereas some operating loupes approach this capability, they become quite uncomfortable in long procedures and are not without their own difficulties in adjustment.

I borrow the standard operating microscope from the otolaryngologist, using a 300 mm focal length lens, though some might find a 250 mm lens more comfortable. It is actually better to have a nonteaching scope; the physician thereby gets a better light intensity and also can progress faster as this is strictly one-man surgery. The assistant has no need of magnification for his role of solution-sponging. This brings up the point that one area in which university microsurgery can make a real contribution, with its heavier case load and its more elaborate equipment and technique — the community surgeon should not be slowed down or feel any obligation in this direction.

The suture material should be nonabsorbable. My choice is 7-0 nylon. There is a vast difference in the ease

The Author

JOHN J. FISHER, M.D.

Dr. Fisher is from the Departments of Obstetrics and Gynecology, Baptist Medical Center, and Memorial Hospital, Jacksonville.

of using this size suture as compared with the next smaller diameter. This was learned only after much struggling with 8-0 and 9-0 nylon in the earlier cases. Although one should be meticulous, a tendency can develop to be overly so, and extra long operating time can be deleterious to good results.

The truly important features of this type surgery are principles that are equally applicable to all surgery; namely, gentle tissue handling, meticulous hemostasis, and careful peritonealization of raw surfaces.

Special microsurgical instruments are readily available today, although our original ones were borrowed from the neurosurgical department. The principle here is that the instruments have fine points. The size of the handle does not have to be correspondingly small. Actually something is gained by having a comparatively large but light handle.

Hemostasis is obtained by sponging with a fine stream of irrigating solution. I use one comprised of 1,000 mg hydrocortisone and 5,000 I.U. heparin in 1,000 cc lactated Ringer's solution. The bleeding point, once identified, is then cauterized with a bipolar current.

The pelvis is packed with lap packs soaked in lactated Ringer's solution, elevating the pelvic structures close to the incisional edge. This affords the operator the advantage of resting the forearm against the wound edge for steadiness. When the surgery has been completed and the packs removed, the pelvis is flushed with a solution of lactated Ringer's with hydrocortisone.

Postoperatively the patient is given Decadron 20 mg every four hours intravenously for 12 doses, and one gm ampicillin intravenously every six hours for the first 24 hours. Hydropertubation is carried out on the second and fourth postoperative days, using 100 cc lactated Ringer's with 500 mg ampicillin and 100 mg hydrocortisone.

Report of Cases

Case 1. — This 28-year-old white female has been married eight years with only a right tubal pregnancy for which she was operated upon in 1974. She consulted us March 16, 1977 for relative infertility. A semen analysis was normal. On May 5, 1977 D&C and laparoscopy were carried out. Curettings revealed ovulation. Inspection of the pelvis revealed the right tube to be present but bound down by many adhesions; the left tube was similar but its end clubbed. Insufflation with methylene blue revealed no passage on the left although the tube distended. On the right side there was a small trickle. The patient was advised to attempt pregnancy for a few months. Her husband was about to be transferred and she requested tubal reconstruction prior to departure. On October 31, 1977 extensive salpingolysis and freeing of the tubes were carried out along with fimbrioplasty of the left tube and salpingostomy of the right. Hydropertubation was successful November 2, 4, and 6. The patient left for California four weeks after surgery. There she delivered a term baby January 1979.

Case 2. — This 26-year-old white female was first seen March 1976. She had delivered a term baby July 1972 but had failed to con-

ceive following two years efforts. Semen analysis was normal. D&C and laparoscopy performed in September 1976 revealed secretory endometrium and bilateral tubal occlusion. In November 1976 bilateral fimbrioplasty and salpingolysis were carried out and hydropertubation on the second, fourth, and fifth postoperative days. She was seen in January 1978 and found to be pregnant, her last menstrual period had been in November. She delivered a term baby in September.

Case 3. — This 34-year-old white female was first seen September 15, 1977. She had delivered four term pregnancies between 1961 and 1966, a modified Pomeroy tubal ligation being carried out October 5, 1966. She had remarried. Her husband's semen analysis was normal. Basal temperature charts revealed ovulation on occasion. The Huhner's test showed a positive result. On December 11, 1978 D&C and laparoscopy were carried out, followed by bilateral reanastomosis of the fallopian tubes. There was no postoperative hydropertubation. The Rubin's test was positive on August 27, 1979. Basal temperature chart showed anovulation, and the patient was placed on Clomid. A pregnancy test was positive on December 29, 1979, but the patient aborted January 22, 1980. Pregnancy was again achieved. The patient called from Hot Springs, Arkansas to report she had aborted on February 22, 1981 at 2½ months gestation. This was confirmed by tissue examination.

Case 4. — This 27-year-old black female had delivered a term baby in 1970. She was treated by her physician in September 1977 for acute pelvic inflammation. He performed a D&C and laparoscopy in December 1977. Secretory endometrium was obtained but no dye entered the left tube and the right tube was clubbed. Tubal surgery was advised. Preoperative workup revealed a semen analysis of only 8 million with 20% abnormal forms. Although the patient was advised against surgery on this basis, she requested that it be performed as her marriage was most likely to be terminated in the near future. On August 1, 1979 lysis of adhesions and bilateral fimbrioplasty were carried out with hydropertubation on August 3 and 6. The Rubin's test on October 5 showed an initial pressure of 120 mm Hg and a maintained level of 100 mm. No pregnancy has been reported. Comment: poor selection of case.

Case 5. — This 32-year-old nulligravida was first seen February 25, 1980. She had a laparoscopy performed on October 24, 1974 with lysis of adhesions and insufflation of dye. No spillage was observed. Preoperative workup revealed a semen analysis of 75 million, her husband having previously fathered a child. Basal temperature chart showed no ovulation, but on Clomid therapy ovulation was demonstrated. On June 19, 1980 bilateral tuboplasty was performed, the patient presenting hydrosalpinx on the left and closure of the fimbriated end on the right. Hydropertubation was successful on the second and fourth postoperative days. Again the basal temperature chart revealed no ovulatory pattern a factor here but short follow-up period and tubal patency not confirmed yet.

Case 6. — This 31-year-old white female had a tubal ligation performed March 1978, having had two difficult deliveries. She was a heavy smoker, divorced, and desired sterilization. A fallope ring had been placed on the right tube in routine fashion, but the attempt on the left side was accompanied by a cutting through of the tube and resort to cauterization. In March 1980 the patient remarried and consulted us for reanastomosis. The husband's semen analysis was 15 million, but consultation with a urologist revealed a varicocele and surgery was performed for its correction. On June 23, 1980 the patient had isthmic-isthmic reanastomosis of the right tube with hydropertubation on the second and fourth days. She was seen November 3, 1980 following two month amenorrhea. The pregnancy test was positive. The patient aborted on November 20.

Case 7. — This 24-year-old female was first seen in the office August 22, 1980, stating that she had had a tubal ligation performed in 1974 in Omaha, Nebraska following delivery of her second pregnancy.

She planned to remarry and wished to have sterilization reversed so she could become pregnant. The operative record of her previous procedure was obtained and showed that a bilateral fimbriectomy had been carried out. Semen analysis of fiancé was carried out and found to be well within normal limits. On September 5, 1980 D&C and Laparoscopy was performed. Both her tubes revealed that good portion remained on both sides. The patient married September 19, 1980 and on November 17th microsurgical tuboplasty with a bilateral fimbriectomy and salpingolysis was carried out. Hydropertubation was successful November 19 and 21. The patient was seen December 29 stating that her period earlier that month had been only of one day duration. The UCG was negative. The patient was seen again March 18, 1981 with the history that her last menstrual period had been January 8. She had nausea, frequency of urination and breast tenderness. Pelvic examination revealed the uterus to be enlarged. Pregnancy test is positive and and EDC of October 18 given.

On March 20 the patient was admitted to the hospital with heavy vaginal bleeding and abdominal cramps during which state she aborted her pregnancy.

Results

Tubal patency has been achieved in 100% of this small series, pregnancy in 71%, and living children in 29% (Table 1). Two of these cases are only 8 months post-operative. Victor Gomel, a pioneer in gynecological microsurgery, is quoted in a recent paper by Garcia and Mastroianni¹ as stating that the majority of pregnancies in his experience have been achieved after 12 months.

The results reported here compare favorably with those of larger series from teaching institutions. Moreover, our case reports demonstrate rather dramatically how results suffer when there is any deviation from the strictest of operative selectivity. As one might expect, better results are obtained in patients younger than 30 years. It is difficult, however, to measure the positive psychological effects achieved by this rather low-risk

surgery even when a term pregnancy is not achieved. Even some large academic centers admit to allowing the desire of the patient, provided she has been fully informed as to all aspects as applied to her individual case, to be their sole prerequisite for these procedures.

Discussion

Stengal and others² in a discussion concerning the prerequisites for this type surgery state that for a physician to present himself as a microsurgeon he should perform a minimum of one such procedure a week. There is some doubt that there are a score of institutions in this country that boast an operator who personally performs 50 such procedures a year. To adhere strictly to such qualifications would restrict greatly the benefits of this type surgery to those women living in those few communities having such a surgical volume.

Wallach³ in a recent paper on the present status of microsurgery questions whether the operating microscope is a prerequisite for achieving good results in several forms of tubal reconstruction, such as lysis of perianaxial adhesions, distal tubal occlusion, and even mid-segment reanastomosis. He goes on to stress the skill of the individual surgeon as being the most important factor.

In my opinion the successful performance of gynecological microsurgery requires the combination of patience on the part of the operator with the triad of gentle tissue handling, meticulous hemostasis, and careful peritonealization of raw surfaces. Special postoperative care has to be added including prophylactic antibiotics, corticosteroids, and hydropertubation.

Conclusion

Microsurgery can be performed successfully in the community hospital by the gynecological surgeon who takes an interest in and observes the requirements of that specialized form of surgery.

More nonacademic surgeons who perform this type surgery should be encouraged to report their results in this field.

References

1. Garcia, C. and Mastroianni, L. Jr.: Microsurgery for Treatment of Adnexal Disease, *Fertil. Steril.* 34:413, 1980.
2. Stengal, J.J.; Eddy, C.A.; Winston, R.L. and Levinson, C.J.: Fallopian Tube Microsurgery, Update 5:6, 1980.
3. Wallach, E. E.: Tubal Reconstructive Surgery — 1980, *Fertil. Steril.* 34:531, 1980.

• Dr. Fisher, Suite 610, Howard Building, Jacksonville 32207.

Table 1.

Patient	Tubal Patency	Pregnancy	Result
1	+	+	Term baby
2	+	+	Term baby
3	+	+ (x 2)	1st trimester abortion
4	+	0	0
5	+	0	0
6	+	+	1st trimester abortion
7	+	+	1st trimester abortion
Percentage	100%	71%	29%

Dysphagia and Cricopharyngeal Myotomy

George L. Kullman, M.D.

Abstract: Thirty-seven cases of myotomy are presented, and the anatomy, physiology and pathophysiology of the cricopharyngeus muscle are discussed. This series indicates that cricopharyngeal myotomy is the treatment of choice for dysfunctions of this muscle, but of questionable value in the treatment of other esophageal disorders presenting with dysphagia.

Dysphagia can be very distressing and debilitating, usually occurring in elderly people, leading at times to weight loss, debility, anxiety, or depressive symptoms. There are several common causes which can be corrected by cricopharyngeal myotomy, particularly if due to spasm or premature contraction of the muscle. Long-term dysfunction of the cricopharyngeus muscle can result in formation of Zenker's pulsion diverticula of the cervical esophagus. However, spasm and dysfunction of this muscle can cause severe dysphagia without producing the x-ray findings of a diverticulum. Several forms of surgical treatment have been used in the past, the most conservative being dilation of the cricopharyngeus muscle with the esophagoscope, as described by Jackson and Shallow¹ in 1925. Inversion and suspension of the diverticulum, a two-stage operation, was described by Lahey and Warren.² Dohlman and Mattsson³ described endoscopic diverticulotomy where the common wall between the esophagus and diverticulum below the sac orifice was divided endoscopically. Direct excision of the esophageal sac, with or without cricopharyngeal myotomy, has been perhaps the most commonly used treatment in recent years.

Cricopharyngeal myotomy as the only treatment for Zenker's diverticulum, cricopharyngeal spasm as well as cricopharyngeal achalasia, has been used on 38 patients in the past 10 years. It is generally considered a safe and effective procedure without mortality and minimal morbidity and can be performed under general or local anesthesia.⁴ Furthermore, CP myotomy is used successfully in conservation surgery of the larynx to promote deglutition following surgery.

Anatomy

The cricopharyngeus muscle is actually a part of the

inferior constrictor of the pharynx and lies at the junction of pharynx and esophagus. It can be described as a muscle sling connecting the two lateral borders of the cricoid cartilage and passing across the posterior wall of the pharynx. The muscle does not have a median raphe. Cricopharyngeal tonic contraction, therefore, acts as a sphincter and prevents involuntary air entry into the esophagus during respiration. The CP muscle blends inferiorly into the circular and longitudinal fibers of the inferior constrictor. The pharyngeal plexus, which is formed by contributions from the vagus and glossopharyngeal nerves, innervates all the pharyngeal muscles including the cricopharyngeus. Sympathetic fibers arise from the superior cervical ganglion and join the plexus. Studies by Rogers,⁵ Kirchner,⁶ Conley,⁷ and Lund⁸ indicate that motor innervation of the CP muscle is vagal in origin. The glossopharyngeal nerve seems entirely sensory since intracranial section leads to no motor dysfunction. The sympathetic supply is antagonistic to vagal action leading to increased sphincter tone. This autonomic innervation is similar to that of other sphincters of the alimentary tract.

Physiology and Pathophysiology

The complex act of swallowing starts with an oral phase which is voluntary and proceeds to an involuntary pharyngoesophageal phase. Immediately before or simultaneously with onset of contraction of the superior constrictor, the cricopharyngeus relaxes. This relaxation lasts for less than one second during which time the inferior constrictor is contracting. The CP muscle contracts again at the end of the inferior constrictor contraction for two to four seconds.⁹ This suggests a reflex arch through the modified submucous plexus and a myenteric plexus located in the external surface of the pharyngeal muscle. The integrity of the bulbar nuclei in the floor of the 4th ventricle, peripheral nerves contributing to the pharyngeal plexus with its sympathetic and parasympathetic contribution, and the musculature of the pharynx are essential for the pharyngeal phase of deglutition. Derangement at any level of this apparatus

The Author

GEORGE L. KULLMAN, M.D.

Dr. Kullman is an otolaryngologist practicing at the St. Petersburg Medical Clinic.

causes upper dysphagia.¹⁰ The exact etiology of muscular incoordination is not known, but a relation between peptic esophagitis with or without hiatus hernia and cricopharyngeal dysfunction is believed to be responsible.

Material and Methods

Thirty-seven patients were operated upon in the past 10 years, 21 males and 16 females, with ages ranging from 55 to 89 years. Twenty of this group had Zenker's diverticula on esophageal x-ray. Eight were diagnosed as cricopharyngeal achalasia, also by x-ray examination. Five patients had neuromuscular dysfunction, one of which had amyotrophic lateral sclerosis, two patients suffered from cerebrovascular accidents, and one had vocal cord paralysis of unknown etiology. The fifth in this group had cancer of the stomach with very "sluggish" motility of the esophagus. All patients had roentgenographic evaluation of their swallowing function but manometric and motility studies were not done.

A fourth group of patients had local malignant disease, one of the trachea involving the esophagus directly. The others had had full-dose radiotherapy to the upper cervical area. All patients had subjective complaints of dysphagia where food would seem to stick in the cervical area with failure to advance.

Operative Techniques

The patient was placed in the recumbent position and the operation was carried out under general endotracheal anesthesia in 19 patients, local infiltration with 1% Xylocaine and epinephrine in the other 18. A 10 cm incision was made along the anterior border of the right sternocleidomastoid muscle. The muscle was retracted laterally, the omohyoid divided, and the thyroid retracted

anteriorly and medially. Middle thyroid and posterior facial veins were divided. The recurrent laryngeal nerve was identified and protected. The cricopharyngeal myotomy was performed on the posterior part of the cricopharyngeus muscle as far away from the recurrent laryngeal nerve as possible. An attempt was made to divide the muscle in the posterior midline if possible. The diverticulum in all cases was left untouched. Wound drainage was accomplished with one hemovac drain and no nasogastric tube was utilized. Wound closure was accomplished in the usual fashion in layers with chromic catgut and silk.

Results

The results are summarized in Table 1. The patients can be divided into two subgroups, first those with definite radiologic evidence of cricopharyngeal dysfunction resulting in a diagnosis of either Zenker's diverticulum or achalasia. The second group showed dysphagia on x-ray examination but the causative mechanism was other than cricopharyngeal disease.

In the first group of patients, it is clearly evident that sectioning of the cricopharyngeus muscle was of great benefit. Twenty-two out of the 28 patients were definitely improved or completely asymptomatic following surgery. The remaining four patients felt that they had persistent dysphagia but none believed it was severe enough to proceed with a second operative procedure for removal of the diverticulum. One patient was lost to follow-up and another patient felt his symptoms were worse after surgery. This particular patient, however, had severe cerebral degeneration due to advanced age and it appeared that his dysphagia had a strong central component.

In the second group of patients with dysphagia caused by conditions other than cricopharyngeal dis-

Table 1. — Results of Cricopharyngeal Myotomy in 21 Males and 16 Females.

Diagnosis	Male	Female	Results				
			Worse	No Better	Better	Well	Lost to Follow-up
Zenker's Diverticulum	11	9	1	2	8	8	1
Achalasia	5	3	0	2	5	1	0
Neuromuscular	2	3	0	3	0	1	1
Regional CA	3	1	2	2	0	0	0

ease, the myotomy seldom produced the desired result. This group has been subdivided into neuromuscular and regional malignant disease problems. Five patients in the neuromuscular group consisted of first a patient with amyotrophic lateral sclerosis with severe dysphagia and weight loss resulting in severe debility. Respiratory failure developed within 48 hours of surgery and this patient represents the only operative mortality in this group. The only successful case was a patient who had sustained a severe cerebrovascular accident with marked dysphagia. He recovered completely following myotomy. The third patient in this group had a CVA 10 years prior to my seeing him. He presented with vocal cord paralysis and aspiration which had started 1-1½ years prior to his surgery. Another patient in this group suffered from CVA of recent onset but neither of these two patients had any appreciable improvement of swallowing function following myotomy. The final patient in this group experienced an esophageal motility problem as seen on the esophageal roentgenogram. He had extensive carcinomatosis of the stomach and following myotomy the motility problem persisted as did his dysphagia.

In the last group of four patients, the reason for the dysphagia was the result of local malignant disease. One patient had carcinoma of the trachea directly involving the anterior wall of the esophagus and myotomy was of no benefit. The other three patients had regional radiotherapy which resulted in edema, pooling of secretions, and apparent loss of sensation of the pharynx and larynx. None were significantly improved by cricopharyngeal myotomy.

Illustrative Cases

Case 1. — Zenker's Diverticulum. A 78-year-old male presented with a history of dysphagia for many years, slowly progressing. X-ray examination showed a 4½ cm diverticulum of the Zenker's type in the upper esophagus. He was admitted to the hospital and under 1% Xylocaine infiltration anesthesia, a cricopharyngeal myotomy was carried out. Postoperatively, there were no complications and within six weeks the patient was eating and drinking normally. Six months after surgery, x-ray of the esophagus showed slight diminution in size of the diverticulum but it is still present, and totally asymptomatic.

Case 2. — Achalasia. A 79-year-old white male was seen with dysphagia and inability to swallow liquids for several weeks duration. The x-ray examination showed retention of contrast material in the pharyngeal area, a lower esophageal ring and hiatus hernia. Preoperatively, esophagoscopy under local anesthesia did not reveal any abnormalities in the cervical esophagus other than a prominent cricopharyngeus muscle. There was no evidence of carcinoma or ulceration in the distal esophagus. The patient underwent cricopharyngeal myotomy under general anesthesia and on follow-up a year later was doing well with only slight residual symptoms of dysphagia.

Case 3. — ALS. A 76-year-old white female seen in consultation with dysphagia due to amyotrophic lateral sclerosis. The patient had noticed a 30 pound weight loss due to inability to eat prior to surgery. The cricopharyngeal myotomy was carried out under general endotracheal anesthesia and the patient did well postoperatively until the

second day. Severe cardiorespiratory difficulties developed and she died 48 hours after surgery. This patient represents the only operative mortality, and it would appear that the additional trauma of the surgery contributed to this severely ill and debilitated patient's demise.

Case 4. — Postirradiation. A 59-year-old white male presented with dysphagia due to an infiltrating squamous cell carcinoma of the larynx which had previously been irradiated. The patient developed, as a primary symptom, continued and severe aspiration requiring a tracheotomy to permit tracheal toilet. A cricopharyngeal myotomy was performed in an effort to relieve this symptom. Followup examination, however, indicates that this procedure did not substantially improve his aspiration problem.

Case 5. — Stroke. A 70-year-old white male was seen in consultation following a severe cerebrovascular accident. The patient was unable to swallow following the stroke and had to be admitted to the hospital with weight loss, dehydration and debility. The patient had a cricopharyngeal myotomy and within a few days was able to increase his oral intake rather dramatically. He was discharged within 10 days following his surgery eating a regular diet.

Discussion

Cricopharyngeal myotomy addresses itself specifically to dysphagia caused by cricopharyngeal dysfunction. As the results indicate, (Table 1) in cases of Zenker's diverticulum or cricopharyngeal achalasia, 22 out of 28 operative patients experienced marked improvement or complete cure. Excision of the diverticulum apparently is not required for relief of symptoms. The advantages of this operation can be summarized as: (1) very short operating time and hospital stay; (2) ability to perform this operation under local anesthesia is of great help in the debilitated patient; (3) ability to resume oral feedings immediately following surgery without the need of Levine tube; (4) elimination of risk of suture line in the esophageal mucosa; (5) elimination of possible morbidity due to mediastinitis.

With problems other than direct cricopharyngeal dysfunction, the results are discouraging. Blakely,¹¹ Calcaterra,¹² and Berlin,¹³ have thoroughly discussed myotomy for the treatment of other causes of upper esophageal dysphagia. It had, therefore, been expected that some of the patients in the neuromuscular group would benefit by this procedure. Likewise, in patients with local malignant disease, especially those after regional irradiation therapy, it would appear that the loss of sensitivity of the mucosa results in dysphagia and aspiration due to lack of initiation of the swallowing reflex. For these cases, also, myotomy was of limited value.

Summary

Anatomy, physiology and pathophysiology of the cricopharyngeus muscle are discussed. Thirty-seven cases of myotomy are presented, 28 for CP dysfunction and nine for other reasons. It is evident that CP myotomy is the treatment of choice for dysfunctions of this

muscle but of questionable value in the treatment of other esophageal disorders presenting with dysphagia. The advantages of this operation are presented.

References

1. Jackson, C. and Shallow, T.A.: Diverticula of Esophagus, Pulsion, Traction, Malignant, and Congenital, *Ann. Surg.* 83:119, 1926.
 2. Lahey, F.H. and Warren, K.W.: Esophageal Diverticula, *Surg. Gynecol. Obstet.* 98:128, 1954.
 3. Dohlman, F. and Mattsson, O.: Endoscopic Operation for Hypopharyngeal Diverticula, *Arch. Otolaryngol.* 71:744-752, 1960.
 4. Hiebert, C.A.: Surgery for Cricopharyngeal Dysfunction Under Local Anesthesia, *Am. J. Surg.* 131:423-427, 1976.
 5. Rogers, L.: Treatment of Spasmodic Dysphagia by Sympathetic Denervation, *Br. J. Surg.* 22:829-832, 1935.
 6. Kirchner, J.A.: Motor Activity of Cricopharyngeus Muscle, *Laryngoscope* 68:1119-1159, 1958.
 7. Conley, J.J.: Swallowing Dysfunction Associated with Radical Surgery of Head and Neck, *Arch. Surg.* 80:602-612, 1960.
 8. Lund, W.S.: Study of Cricopharyngeal Sphincter in Man and in Dog, *Ann. R. Coll. Surg. Engl.* 37:225-246, 1965.
 9. Code, C.F. and Schlegel, J.F.: Motor Action of Esophagus and Its Sphincters, in *Handbook of Physiology: Alimentary Canal*, Bethesda, Md., American Physiologic Society, 1967, Vol. 4, pages 1821-1839.
 10. Zuckerbraun, L. and Bahna, M.S.: Cricopharyngeus Myotomy as Only Treatment for Zenker's Diverticulum, *Ann. Otol.* 88:798-803, 1979.
 11. Blakely, W.R., Garety, E.J. and Smith, B.E.: Section of Cricopharyngeus Muscle for Dysphagia, *Arch. Surg.* 96:745-762, 1968.
 12. Calcaterra, T.C., Kadel, B.M. and Ward, P.H.: Dysphagia Secondary to Cricopharyngeal Muscle Dysfunction, *Arch. Otol.* 101:726-729, 1975.
 13. Berlin, B.P., Furstein, J.T., Tedesca, F., et al.: Manometric Studies of Upper Esophageal Sphincter, *Ann. Otol. Rhinol. Laryngol.* 86:598-602, 1977.
- Dr. Kullman, 501 11th Street North, St. Petersburg 33705.

Successful Repair of Interventricular Septal Defect Resulting From Blunt Chest Trauma

Shaik A. Khuddus, M.D., Hooshang Bolooki, M.D., Ahmad Rashid, M.D.,
Hooshang Kadivar, M.D., and William H. Meyer Jr., M.D.

Abstract: Ventricular septal defect is a known complication of penetrating chest trauma but it also can result from blunt chest trauma, although caused by a different mechanism. Septal rupture may be detected in the patient with minimal or no external injury following blunt chest trauma. Prompt diagnosis is important; effective correction can be achieved with available surgical techniques. In the patient with systolic murmur, that is, EKG changes compatible with acute myocardial infarction, ventricular septal defect should be strongly suspected. A case is presented of interventricular septal defect resulting from a blunt chest injury which was surgically closed successfully.

More than 20 surgical repairs of interventricular septal defect caused by blunt trauma have been reported. Previous reports emphasize early cardiac catheterization followed by repair. Our case manifested rather quick hemodynamic deterioration and significant congestive heart failure developed requiring urgent surgical repair.

Case Report

A 25-year old black man was admitted to the Fort Pierce Memorial Hospital on 3/7/76 following an auto accident in which he sustained blunt steering wheel injury to the left chest. At the time of the accident, his vehicle had been suspected of traveling at a speed exceeding 80 miles per hour.

On admission a left hemothorax was treated with prompt thoracotomy. Cardiovascular examination was unremarkable except for tachycardia, which was diagnosed to be sinus in origin on EKG. There was no clinical evidence of congestive heart failure. In the early morning of 3/8/76 the patient was noted to be markedly orthopneic, dyspneic and tachypneic. Physical examination revealed acute left ventricular failure. There was significant tachycardia and a loud holosystolic murmur grad IV/VI was well heard at the apex and the lower left sternal margin. Chest x-ray (Fig. 1) showed marked pulmonary vascular congestion with mild cardiomegaly. EKG (Fig. 2) showed sinus tachycardia, intraventricular conduction defect, left axis deviation and changes in the precordial leads compatible with acute anterior wall myocardial infarction.

The Authors

SHAIK A. KHUDDUS, M.D., HOOSHANG BOLOOKI, M.D.,
AHMAD RASHID, M.D., HOOSHANG KADIVAR, M.D., WILLIAM
H. MEYER JR., M.D.

Dr. Khuddus, Dr. Rashid, Dr. Kadivar and Dr. Meyer are from the Department of Surgery and Medicine, Lawnwood Medical Center, Fort Pierce, and Dr. Bolooki is from the Department of Thoracic and Cardiovascular Surgery, University of Miami School of Medicine, Miami.

The patient was treated with digitalis, diuretics and O₂ administration. Thoracotomy drainage was continued. A central venous line was inserted which showed a right atrial pressure of 12 cm H₂O. A diagnosis of ventricular septal defect due to blunt chest trauma was made and the patient was immediately transferred to Jackson Memorial Hospital, Miami, for consideration for surgery. A Swan-Ganz catheter inserted later confirmed the diagnosis of ventricular septal defect as evidenced by the pressure of oxygen concentration step-up in the right ventricle. The pulmonary artery diastolic pressure and the pulmonary capillary wedge pressure were elevated abnormally indicating left ventricular failure.

The patient's condition continued to deteriorate despite aggressive medical therapy and he was taken to surgery on 3/8/76. The ventricular septal defect was successfully repaired utilizing a teflon mesh graft. His postoperative course was uneventful except for a mild episode of postcardiotomy syndrome which was treated appropriately.

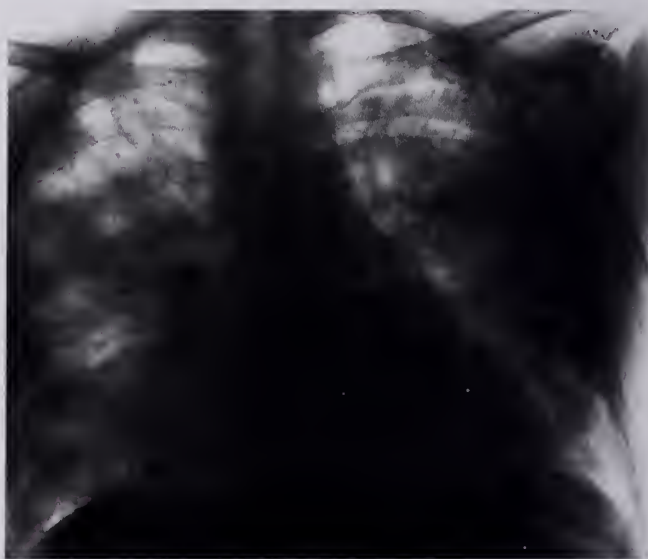


Fig. 1. — Chest x-ray on admission showing cardiomegaly and marked pulmonary vascular congestion.

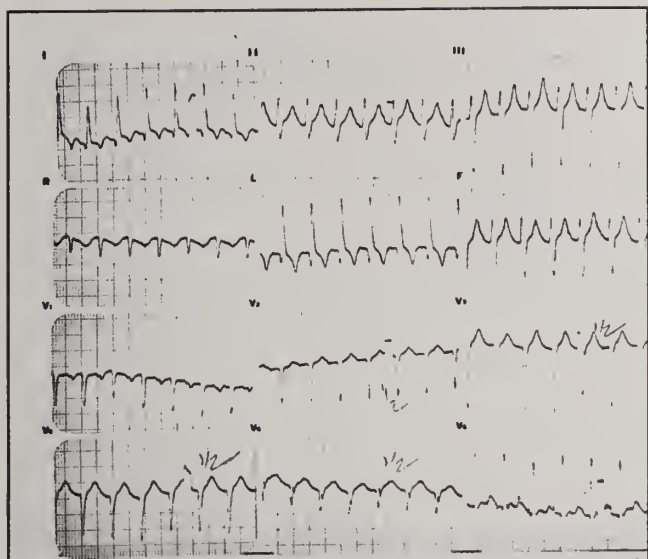


Fig. 2. — Electrocardiogram on admission showing sinus tachycardia and changes compatible with anterior wall myocardial infarction.

On the 21st postoperative day he was subjected to cardiac catheterization and no intracardiac shunt was detected. Hemodynamics were normal. He was discharged on the 24th postoperative day on digitalis and diuretics which were later discontinued. The patient had no further evidence of congestive heart failure and went back to full-time employment as a laborer. More than four years later he continues to be active, working, and asymptomatic.

Discussion

The exact incidence of ventricular septal defect in cases of nonpenetrating trauma is unknown. The first reported case of traumatic ventricular septal defect was by Hewett in 1847.¹ In one series of 152 cases with cardiac lesions due to nonpenetrating trauma, Bright and Beck noticed 11 cases with tears in the interventricular septum.² Parmley et al found rupture of the interventricular septum in 30 of the 546 cases studied with blunt chest trauma.³ Interestingly, in these cases of blunt chest trauma accompanied by cardiac injury, skeletal damage may or may not be present. In the report by Bright and Beck rib fractures were noted in only 58 of the 152 cases. In a series of 250 blunt chest injuries Arenburg found that cardiac damage occurred without rib fracture.⁴ Dunseth and Ferguson reported that severe myocardial damage and perforation of the interventricular septum occurred more frequently when there was no fracture of the ribs.⁵ This supports the theory that the thoracic wall has a protective influence in dissipating energy input forces. It is, therefore, not uncommon to find serious cardiac damage without obvious chest wall injury. Serious cardiac damage is more likely to occur when the causative force is frontal and the heart is compressed between the sternum and the spine.⁶

The mechanism of the interventricular septal rupture has been well described by Bright and Beck.² It is believed to occur because of the compression of the heart between the sternum and the spine by the action of direct forces or by extreme changes in the intrathoracic pressures during sudden deceleration. The greatest period of vulnerability appears to be either in the late diastole or early systole when the cardiac volume is larger. During these phases the ventricles are distended, valves are closed and relief of pressure is not possible.

Patients with ruptured interventricular septum are extremely sick. As previously stated, external injuries have no bearing upon the cardiac damage. Acute left ventricular failure or congestive heart failure develops in most patients. A systolic thrill is usually noticed along the lower left sternal border accompanied by a harsh holosystolic murmur. Chest roentgenogram generally shows pulmonary congestion and cardiomegaly. The symptoms of traumatic rupture of the interventricular septum are shock, dyspnea, cyanosis, orthopnea and sometimes hemoptysis. The triad of chest trauma, systolic murmur, and an infarct pattern on the EKG should suggest the diagnosis of an acquired ventricular septal defect. Rosenthal et al report that small defects with small shunts and no symptoms should be observed.⁷ Some of these defects may close spontaneously. Spontaneous closure of a residual ventricular septal defect after surgical repair of traumatic interventricular septal defect has been reported.⁸ The prognosis in general depends on the size of the defect and other associated cardiac and noncardiac injury.

Although cardiac catheterization and coronary angiography are generally done prior to corrective surgery, in our case, due to rapid clinical deterioration, surgical repair of the interventricular septal defect was carried out on the basis of clinical findings and beside hemodynamic monitoring. In the case presented, the typical triad was noted: chest trauma, systolic murmur, and a pattern compatible with myocardial infarction on EKG. This generally should suggest the diagnosis of traumatic interventricular septal defect. Surgery is definitely indicated in patients with persistent heart failure and in those with pulmonary hypertension.

Acknowledgments

We wish to thank Mrs. Claire L. Bould and Mrs. Carolyn A. Miller for their help in preparing this manuscript and also the Intensive Care Nursing Staff and Tom O'Connell, Librarian.

References

1. Hewett, H.: Rupture of Septum Ventriculorum, *London Medical Gazette* 4:870-872, 1847.
2. Bright, E.F. and Beck, C.S.: Nonpenetrating Wounds of Heart: Clinical and Experimental

- Study, *Am. Heart J.* 10:293-321, 1935.
3. Parmley, L.F.; Manion, W.C., and Mattingly, T.W.: Nonpenetrating Traumatic Injury of Heart 18:371-379, 1958.
 4. Arenberg, H.: Traumatic Heart Disease: Clinical Study of 250 Cases of Nonpenetrating Chest Injuries and Their Relation to Cardiac Disability, *Ann. Int. Med.* 19:326-330, 1943.
 5. Dunseth, W. and Ferguson, T.B.: Acquired Cardiac Septal Defect Due to Thoracic Trauma, *J. Trauma* 5:142-149, 1965.
 6. Pierce, E.C.; Dabbs, C.H., and Rawson, F.L.: Isolated Rupture of Ventricular Septum Due to Nonpenetrating Trauma. Report of Case Treated with Open Cardiotomy Under Simple Hypothermia 77:87-91, 1958.
 7. Rosenthal, A.; Pansi, L.E., and Nadas, A.O.: Isolated Interventricular Septal Defect Due to Nonpenetrating Trauma. Report of Case with Spontaneous Healing, *New England J. Med.* 283:338-341, 1970.
 8. Karjcer, Z.; Cooley, D.A., and Leachman, R.D.: Ventricular Septal Defect Following Blunt Trauma; Spontaneous Closure of Residual Defect After Surgical Repair, Catheterization and Cardiovascular Diagnosis 3:409-415, 1977.
- Dr. Khuddus, 2215 Nebraska Avenue, Suite 2E, Fort Pierce 33450.

The Florida Statewide Health Coordinating Council What Is It?

Emmet F. Ferguson Jr., M.D.

Public Law 93-641 passed the U.S. Congress as the National Health Planning and Resources Development Act of 1974. Prior to its enactment, Congress had required that states adopt health plans as a condition for participating in federally funded programs. Those conditions included requiring plans for the provision of health services to crippled children, the aged, blind, indigent, and disabled; for the construction of hospitals, nursing homes, out-patient and other health facilities for mental health or for the treatment of the mentally retarded; for the operation of programs relating to heart disease, cancer, and stroke; for the construction and operation of facilities or programs to deal with alcoholism or drug abuse, and other federally funded programs.

The National Health Planning and Resources Development Act is embodied in Title XV of the Public Health Services Act, expanding the federal Comprehensive Planning and Hill-Burton Acts. The newer Act of 1974 established 205 health service areas and 205 Health Systems Agencies (HSAs) for each area, creating in effect a federal network of planning agencies on a nationwide basis, charged with designing health systems plans for coordinated federal funding and programming. In each state these plans are to be effectuated in conjunction with a State Health Coordinating Council (SHCC) and the State Health Planning Agency (SHPDA), as established by the Act. SHCC and SHPDA develop

statewide health plans and provide support to the HSAs, of which there are nine in Florida. All these organizational entities are subject to the Secretary of the Department of Health and Human Services (HHS), formerly the Department of Health, Education, and Welfare (HEW).

Health Systems Agencies

Florida's HSAs are depicted in Figure 1. These areas are determined according to several criteria, which include: at least one center for highly specialized health services; population; and to the extent feasible coordinated with the boundaries of Professional Standards Review Organizations. An HSA may be a non-profit corporation; a public regional planning body; or a single unit of general local government. Membership of an HSA shall be not more than 60 percent consumers who are broadly representative of the principal social, economic, linguistic, handicapped populations, and major purchasers of health care services in the area. Not less than 40 percent of the membership must be providers of health care, with one-half being direct providers of health care services.

The functions of an HSA are myriad. However, they can be summarized as follows: improving the health of residents; increasing the accessibility, acceptability, continuity and quality of health services; containing health care costs; recommending certificates of need; preventing unnecessary duplication; improving competition; establishing and implementing health systems plans; coordinating activities with PSROs and model cities projects; reviewing and approving or disapproving the proposed use of federal funds by any entity other than the state, unless such resources are to be used solely within the health service area of the HSA.

The Author

EMMET F. FERGUSON JR., M.D.

Dr. Ferguson serves as President of the Florida Statewide Health Coordinating Council (SHCC) by appointment of Gov. Bob Graham. A Past President of the Duval County Medical Society, Dr. Ferguson practices colon and rectal surgery in Jacksonville.

State Health Coordinating Council

Florida's SHCC has 30 members. The Governor shall select from a list of nominees submitted by an HSA, at least twice the number of representatives to which they are entitled. Of the HSA representatives on the SHCC, not less than one-half shall be consumers of health care. Up to 40 percent of the total SHCC membership shall be at large appointments by the Governor. The SHCC shall meet once per quarter and hold its meetings public.

Functions of the SHCC are to: establish a uniform format for Health Service Plans; describe the institutional and other health services needed in the state, the number and types of resources needed to meet the State Health Plan goals, and the need for health facility construction, modernization, conversion or closure; review HSA budgets, recommend approval or disapproval of federal funds; and make recommendations for needed health related legislation.

State Health Planning and Development Agency

Under the National Health Planning and Resources Development Act of 1974 the Governor designates the SHPDA, which in Florida is organizationally housed within the Department of Health and Rehabilitative Services, under the directorship of the Deputy Assistant Secretary for Health Planning and Development.



Fig. 1

The functions of the SHPDA are to: conduct the health planning activities of the state; determine state-wide health needs; review HSA Health Service Plans and submit them to the SHCC; assist the SHCC in the performance of its functions; administer a State Certificate of Need Program that applies to capital expenditures; institutional health services, and the acquisition of major medical equipment; consider the appropriateness of existing institutional and home health services; prepare and report to the HSAs an inventory of health facilities in the state and on an ongoing basis evaluate their physical condition; provide technical assistance in obtaining and filling out the necessary forms for the development of projects and programs; and submit the State Health Plan to the Secretary of the U.S. Department of Health and Human Services for approval or disapproval of related federal funding and programming.

Public Law 96-79

The National Health Planning and Resources Development Act of 1974 was amended in 1979 by Congress. Two important amendments of Public Law 96-79 enable the Governor to change the boundaries of HSA service areas upon approval of the Secretary of HHS, and require that the State Health Plan shall not be submitted to the Secretary of HHS until approved by the Governor.

Summary

The National Health Planning and Resources Development Act of 1974 established a federal network of health planning agencies which in essence bypassed state governments. The constitutionality of the Act was challenged as a violation of state's rights under the Tenth Amendment. The Act's constitutionality was upheld in federal district court. However, Public Law 96-79 amended the Act to provide a more significant role for a governor of a state in the federally created network of state health planning. The future of HSAs, SHCC, and SHPDA are still tied to the constitutional issue previously raised, which remains unsettled, and also with the Reagan Administration's interpretation of the appropriate role of the federal government in State Health Planning.

● Dr. Ferguson, 1515 May Street, Jacksonville 32204.

Practicing Physicians, Past-Present-Future

Kenneth E. Penrod, Ph.D.

There is widespread perception today that we are in the midst of change from a shortage of physicians to what some believe will become a surplus. Does this apply in Florida, one of the fastest growing states in the nation?

This question is being asked by some who are affected by the consequences — legislators, other governmental officials, and educators, as well as many physicians. Is any shift in policy indicated at this time, or in the near future?

To provide a sound basis for policy determination, some factual data are needed relative to adequacy of our physician population today, current trends in supply, and some indication of what we can expect in the next decade.

But first a brief discussion of the ways in which physician manpower is usually expressed.

Licensed Physicians

Knowing the number of physicians who are licensed to practice in Florida is useful for many purposes but it has limitations. One of its principal assets is the ease of obtaining up-to-date information from the Department of Professional Regulation.

Data are available for the licensees for medicine (M.D.) and for osteopathic medicine (D.O.) separately and can be divided into the number residing in the state, in other states and in foreign countries. The data for March 1981 are:

	M.D.	D.O.
Total licensed	30,928	3,224
Florida addresses	18,161	1,008
Other states	12,556	2,213
Foreign	211	3

Those currently living in Florida are of greatest

interest. The number holding a license but not now living here is of interest primarily as a potential source for rapid immigration. However, this pool has remained remarkably stable over the past decade at about 40% of all licensed M.D.'s and about 70% of all licensed D.O.'s.

The total number of licensed physicians in the state, usually expressed as a ratio of physicians-to-population, is often used to compare states. This comparison is valid only to the extent that it measures the same thing in different states. One limitation of this figure is the inclusion of an unknown proportion who are retired, inactive, partially active or engaged in other than patient care activities. So the total number of licensed physicians in the state should not be confused with the number who are actually providing medical services.

Medical Society Data

Neither the Florida Medical Association nor the Florida Osteopathic Medical Association claims to number all of the physicians in the state, active or otherwise, among its members. However, these figures probably come closer to representing the clinically active physicians in the state than do the licensure data although they may not include many clinically active doctors such as faculty members, housestaff and federally employed physicians.

As of 1 January 1981, the Florida Medical Association total membership was 13,389, of which 478 were listed as retired. The number of "regular active members" was 10,855.

Data from the Florida Osteopathic Medical Association for the same date was a total of 760 members, 60 of whom are retired.

Census by Specialty

Since the services rendered vary so widely among practitioners in the many specialties (there are 23 specialty boards but over 130 specialty societies), it is sometimes desirable to separate the pool of licensed physicians into their types of practice.

Data in this form are being compiled in the Master-file of the American Medical Association for all holders of the Doctor of Medicine degree. By tapping the known

The Author

KENNETH E. PENROD, PH.D.

Dr. Penrod is Staff Director, Community Hospital Education Program, Tallahassee.

sources, e.g., medical schools, immigration reports, licensure boards, and others, each new addition to the profession can be added. Through periodic surveys an effort is made to update each record.

Unfortunately there are limitations to the use of these data. Self designation of specialty tends to cause overestimation of specialty data and underestimation of general medical care; physicians die, retire, change activity, and in such a large file some "get lost". The file has a large and growing "non-classified" category and finally the data are unavoidably out-of-date. For instance, the data available in February 1981 was current only through December 1979.

The American Osteopathic Medical Association likewise maintains a Masterfile for holders of the D.O. degree. While this file is much smaller it too has some of the liabilities ascribed above to the AMA Masterfile.

The remaining alternative is considerable effort at the local level using many data sources to compile a roster of practicing physicians by type of practice. *The Geographic and Specialty Distribution of Physicians in Florida* has recently been prepared by this office. The data were for Fall 1980 and, to the extent possible, represents only currently active physicians (M.D. and D.O.). All known to be retired, active for only a few hours per week and all 70 years old or older, regardless of activity, have been excluded.

The total number of physicians found to be active in Florida in the fall of 1980 was:

Private Practice	13,913
Medical School Faculty	684
Interns and Residents	1,890
Federally Employed	742
Federally Employed Residents	75
State Employed	440
TOTAL	17,744*

*(16,846 M.D.'s, 898 D.O.'s)

Members of these groups are not equally engaged in patient care. For instance: interns and residents are both learners and providers; faculty teach and do research in addition to seeing patients. The Graduate Medical Education National Advisory Committee (GMENAC), after studying available data on allocation of resident time among patient care, education, and research, concluded that "residents provide direct health services at approximately 35% the level of a full-time practicing physician". GMENAC also examined the activities of faculty members but, finding it too difficult to dissect their many activities, decided to include in their county "physicians en-

gaged primarily in research, teaching and administration as well as patient care".

Numbers, to have meaning, generally need a reference point. GMENAC has invested a large amount of time and money in the last three years in an attempt to define, among other things, how many physicians practicing a given specialty are needed to serve an average population of a given size. While their "requirements" figures were constructed to apply in the health care delivery environment of 1990 as they now perceive that to be, it is not totally inappropriate to use these requirements as reasonable target figures for today.

To conform with GMENAC standards the count of active Florida physicians in late 1980 has been made with the housestaff in each specialty factored as 35% of full-time practitioners, and all others counted full-time.

Based on a Florida population in the fall of 1980 of 9.8 million (it was officially 9.74 million on 1 April 1980) the present status of manpower in a number of selected specialties, compared with GMENAC standards, is shown in the accompanying table.

The significance of the surplus-shortage figures may be challenged on the grounds of reference to GMENAC requirements. Those requirements were constructed to apply to an average U.S. population. Our population is significantly skewed toward the elderly (17.67% now and projected to be over 20% by 1985 compared with about 11% for the U.S. average). We also have approximately 35 million short-term visitors to the state per year and this is projected to increase to 45 million by 1985. Their average stay in the state in 1979 was 9.7 nights for air travelers and 16.4 nights for those traveling by automobile.

Obviously the extra demands for physician services imposed by the elderly and by visitors do not fall equally across all specialties. The impact of these two factors on each specialty needs further study.

Knowing the present status is useful mainly as a guide to what must be done to improve our position in the future, yet forecasting future physician manpower needs is a hazardous venture. The variables are many and most are unclear.

Two questions bearing heavily on predictions for the future are: Given the rate of growth of the population of Florida, is the physician supply keeping up? And, can the growth curve for physicians seen in the last decade be projected to the 80's?

In the decade of the 70's the state's population grew 2.95 million (43%). In the same period the number of licensed physicians increased 10,764 (133%). But while the total number of licensed physicians clearly outstripped the population growth of the state, not all of the specialties shared equally in this increase. This conclusion is based on comparable data of 1978 and 1980 during which

the population growth was estimated at 900,000. In that period the growth of six specialties appeared to lag behind the demands for general population growth. These were: Internal Medicine, -133; General/Family Practice, -99; Psychiatry, -34; Child Psychiatry, -33; Otolaryngology, -10; and Pediatrics, -5.

The growth rate of the total number of licensed physicians in Florida has been surprising by linear since the early 1970's for both M.D.'s and D.O.'s. If that growth is projected in a straight line to 1990, the total number licensed and in the state would be 28,230 M.D.'s and 1,415 D.O.'s. The most recent forecast for the state's population growth in the 80's is between 1.0 and 2.85 million. So again physician growth would far exceed population growth.

But the assumption of continued physician growth at the rate of the past may be questioned. During the past decade 33 new medical schools were added (25 M.D., 8 D.O.). The number of students graduated annually increased from 8,797 to 16,182 and the number of interns and residents in training increased by more than 20,000. That kind of growth in the educational establishment will not continue.

GMENAC supply projections anticipate continued increase in M.D. graduates until 1982-83, then a leveling off at 18,151 per year. The output of D.O.'s is expected to increase until 1987-88 when a total of 1,868 per year will be reached. If these figures hold the total number of medical school graduates will increase 24% between 1980 and 1990, far short of the 84% increase between 1970 and 1980.

It is very difficult at this time to predict the impact of foreign medical graduates (FMG's) on the future physician supply in Florida. The trend is definitely down due both to a 1976 law curtailing FMG immigration into the U.S. and to a decreasing inflow of Cuban physicians to Florida. An opposing force is the sizeable pool of United

1980 Florida Physician Supply by Specialty

Specialty	Active Physicians in Florida (M.D. + D.O.)	GMENAC Requirements	Surplus (Shortage)
Family/General Practice	3,148	3,381	(233)
General Internal Medicine	1,749	2,827	(1,078)
General Pediatrics	863	1,217	(354)
Obstetrics/Gynecology	1,040	966	74
Emergency Medicine	630	543	87
Allergy	91	82	—
Cardiology	461	312	149
Dermatology	273	280	—
Gastroenterology	183	262	(79)
Hematology/Oncology	148	362	(214)
Nephrology	99	111	—
Pulmonary Diseases	156	145	—
Rheumatology	65	68	—
General Surgery	1,136	946	190
Neurosurgery	145	107	38
Ophthalmology	631	467	164
Orthopedic Surgery	680	608	72
Otolaryngology	314	322	—
Plastic Surgery	197	109	88
Thoracic/CV Surgery	199	82	117
Urology	429	310	119
Psychiatry	870	1,549	(679)
Child Psychiatry	64	362	(298)

States citizens now enrolled in foreign medical schools. Estimates of the number vary from 10,000 to 15,000. There can be little doubt that these students all intend to return to the U.S. to practice medicine.

A vast change has occurred in the proportion of women medical students in the past decade and this could be a factor in future manpower projections. In 1970, women accounted for 11.1% of the first-year class in medical schools (M.D.) but by 1980 their proportion had grown to 28.9%.

The story is similar in the osteopathic medical schools: 2.8% of the graduates in 1970 and 18.1% of the 1980 graduates were women.

Historically women physicians as a group have devoted fewer hours per week and less total years to the profession than have their male colleagues. But this appears to be changing. Recent data point to a convergence of productivity among male and female doctors. Also, interestingly enough, specialty choices of women are

becoming much like those of male graduates.

Finally, there will be a much larger pool of physicians in the U.S. in the next decade than there has been in the past. The data assembled by GMENAC points to an increase of 160,950 active physicians between 1978 and 1990, which is a 43% increase. To what extent will they be affected by the "Sunbelt Syndrome"?

Summary

Florida has experienced an increase of 133% in the number of physicians in the state over the decade of the 70's. In consequence many of the specialties now appear to be well supplied on a statewide basis. This says nothing, however, about their geographic distribution.

There are still some serious shortages, especially among the primary care specialties, and psychiatry.

It is virtually impossible at this time to predict with any confidence what the next decade will bring in the way of meeting physician manpower demands. But some of

the important variables are discussed, along with their implications.

The overall picture would seem to suggest it is too early to begin tinkering with the supply system in Florida. While it is clear that some specialties are in short supply, and perhaps need special attention, the apparent oversupply of other specialties is not yet serious enough to call for action, especially in the light of the many variables which are as yet obscure.

But we are in a new era of physician supply which calls for closer assessment and planning than has been the case in the past.

References available from the author upon request.

- Dr. Penrod, 107 West James Street, Tallahassee 32304.

Preventive Medicine A New Perspective

Martin L. Schulkind, M.D.

Preventive medicine as defined in the classical textbook by Levell and Clark is broader than merely the prevention of occurrence of disease. It states that "medicine must also be concerned with the promotion of health and the prevention of total disability by the rehabilitation of those damaged by the disease process."¹ Hilliboe in another classical text defines preventive medicine "as that aspect of the physician's practice in which the physician applies to individual patients the knowledge and techniques of medical, social and behavioral science to prevent disease and/or its progression."² In contrast, Hilliboe defines public health "as the science and art of applying knowledge and skills from medical and allied sciences in an organized community effort toward maintaining and improving the health of groups of individuals."

The linked concepts of disease prevention and health promotion are not novel. The ancient Chinese classical texts discussed ways of life to maintain good health. In classical Greece the followers of the gods of medicine associated the healing arts not only with the god Aesculapius, but with his two daughters, Panacea and Hygeia. While Panacea was involved with the medication of the sick, her sister Hygeia was concerned with living wisely and preserving health.

In the modern era there has been periodic surges in interest leading to major advances in prevention. The sanitary reforms of the latter half of the nineteenth century and the introduction of effective vaccines in the middle of the twentieth century are two examples. Two examples to which has been ascribed much of the increase in life expectancy that we are experiencing at the present time. However, during the 1950s and 1960s most concern was with the treatment of chronic diseases, and the relative lack of knowledge of their causes resulted in the decline in emphasis on prevention. Now, however,

with the growing understanding of causes and risk factors for chronic diseases, the 1980s present new opportunities for major gains. As our surgeon general, Julius Richmond, says in his report entitled *Healthy People* (the 1979 report on health promotion and disease prevention), "prevention is an idea whose time has come."³ We have the scientific knowledge to begin to formulate recommendations for improved health. And although the chronic degenerative diseases differ from their infectious disease predecessors in having more and more complex causes, it is now clear that many are preventable. Dr. Richmond goes on to list the challenges for prevention in the 1980s; he lists cigarette smoking as the most important preventable cause of death; alcohol and drugs, where the misuse of alcohol and other drugs causes a substantial toll of premature death, illness, and disability. Alcohol is a factor in more than 10% of all deaths in the United States. He lists occupational risks, whereby it is estimated that up to 20% of total cancer mortality may be associated with occupational hazards; accidental injuries, accidents account for roughly 50% of all the deaths of individuals between the ages of 15-24, but actually the highest death rate from accidents occurs among the elderly whose risk of fatal injuries is nearly double that of adolescents and young adults. We also know we could probably save lives and extend life by following judicious diets and exercise programs as well as maintaining a perspective towards health which is a positive one.

In 1974 the government of Canada published "A New Perspective on the Health of Canadians."⁴ It introduced the useful concept which views all causes of death and disease as having four contributing elements: 1) inadequacies of the existing health care system, 2) behavioral factors or unhealthy life styles, 3) environmental hazards, and 4) human biological factors.

Using that framework, a group of American experts developed a method for assessing the relative contributions of each of the elements to many health problems.³ Analysis in which the method was applied to the ten leading causes of death in 1976 suggests that perhaps as much as half of the U.S. mortality in 1976 was due to unhealthy behavior or lifestyle; 20% to environmental factors; 20% to human biological factors; and only 10% to

The Author

MARTIN L. SCHULKIND, M.D.

Dr. Schulkind is with the Departments of Community Health and Family Medicine and Pediatrics, University of Florida College of Medicine, Gainesville.

inadequacies in health care.

Even though these data are approximations, the implications are important. Lifestyle factors should be amenable to change by individuals who understand and are given support in their attempts to change. Many environmental factors can be altered at relatively low costs. Inadequacies in disease treatments should be correctable within the limits of technology and resources as they are identified. Even some biological factors, for example genetic disorders currently beyond effective influence may ultimately yield to scientific discovery. There is cause to believe that further gains can be anticipated. The surgeon general utilized this information to state that "it is necessary now for us to reexamine our priorities for national health spending. Whereas currently only four percent of the federal health dollar is specifically identified for prevention-related activities, it is clear that improvement in the health status of our citizens will not be made predominantly through the treatment of disease, but rather through its prevention." This is recognized in the growing consensus about the need for, and value of, disease prevention and health promotion.

Opportunities in Prevention

Several recent conferences at the national level have been devoted to exploring the opportunities in prevention. Professional organizations in the health sector are reevaluating the role of prevention in their work. The President and the Secretary of the now Department of Health and Human Services have made strong public endorsements of prevention, and a rapidly growing interest has emerged in the Congress of the United States.³ Similar to the Federal interest, there is interest in the state health agencies in preventive medicine. It is clear now that: first, prevention saves lives; second, prevention improves the quality of life and; third, it can save dollars in the long run, and in an era of runaway health costs, preventive action for health is cost effective. In the surgeon general's recent report his central theme is that "the health of this nation's citizens can be significantly improved through actions individuals can take themselves and through actions decision-makers in the public and private sectors can take to promote a safer and healthier environment for all Americans at home, at work, and at play."³

For the individual, often only modest lifestyle changes are needed to substantially reduce risks for several diseases. And many of the personal decisions required to reduce risk for one disease can reduce it for others. Within the practical grasp for most Americans are simple measures to enhance the prospects of good health including the elimination of cigarette smoking; the reduction of alcohol misuse and other substance abuse;

moderate dietary changes to reduce the intake of excess calories, fat, salt, and sugar; moderate regular exercise; periodic screening for major disorders such as hypertension, certain cancers, and the adherence to speed laws, the use of seat belts and the appropriate car restraints for children. The surgeon general claims that widespread adoption of these practices could go far to improve the health of our citizens.

What is Health Promotion?

Medical care begins with the sick and seeks to keep them alive, make them well, or minimize their disability. Disease prevention begins with the threat to health — a disease or environmental hazard — and seeks to protect as many people as possible from the harmful consequences of that threat. Health promotion begins with people who are basically healthy and seeks the development of community and individual measures which can help develop lifestyles that can maintain and enhance the state of well-being. Clearly the three are complementary and any effective national health strategy must encompass and give due emphasis to all of them.

Beginning in early childhood and throughout life, each of us make decisions affecting our health. They are made, for the most part, without regard to our contact with the health care system. Yet their cumulative impact has a greater effect on the length and quality of life than all the efforts of medical care combined.

Many factors increasing the risk of premature death can be reduced without medication. Some factors which have been noted are the striking decline in heart disease death rates in this country since the mid 1960s which has coincided with reductions in several risk factors: cigarette smoking by men, consumption of high fat products, average serum cholesterol levels, and the number of people with untreated high blood pressure. During the same period in Europe, neither personal risk factors nor heart disease death rates declined.³

We must also consider for example the striking lower cancer rates among certain groups of Americans compared to those for the general population. Seventh Day Adventists neither smoke nor drink and about half follow a milk, egg, and vegetable diet. For this group, not only is their cancer incidence, for those cancers strongly related to smoking and drinking, less than one-seventh that of the general population; even their cancer incidence at other sites is only half to three-fourths as high. Similarly, Mormons, who also abstain from smoking and alcohol have lower cancer rates.³

In addition there are some promising results coming from recent efforts to organize community resources for health promotion. The Stanford Program, begun in 1972, has been monitoring the rates of cigarette smoking,

serum cholesterol levels, and uncontrolled hypertension in three northern California communities.³ Two of the three employed active risk reduction activities, including messages designed for television, radio, newspapers, and other media. In one of these two communities, face to face counseling also was provided for a sample of high risk individuals. Within a two year period in the two experimental communities, the overall heart disease rate fell by about 25%. In both, there were reductions of average serum cholesterol levels and 6% lowering of systolic blood pressure. A substantial reduction (net decrease of 35%) in smoking was achieved among the high risk individuals receiving counseling. In the community without an active information program, overall risk for heart disease actually increased during the first two years of the study.

Another example of a program of intervention is the Multiple Risk Factor Intervention Trial Program which seeks to change behaviors with respect to smoking, serum cholesterol, and high blood pressure.³ This is a multi-center clinical trial in 20 communities to determine whether, for men at high risk, a concentrated program based on counseling and directed simultaneously towards the three risks will result in a significant reduction in heart disease deaths. Although final study results will not be available until 1983, preliminary data are especially encouraging with respect to the number of participants who have stopped smoking and those whose high blood pressure is under control. Moderate cholesterol reduction has also been achieved.

Benefits to Physicians

What are the benefits to the physician in practicing preventive medicine? There are many rewards to the program. The prevention-minded physician is alert for chances to prevent the occurrence or progression of disease among patients and their families. An alertness which must usually be acquired. Once it is acquired it becomes second nature to the physician to be on the lookout for congenital defect in the newborn, rehabilitation needs among stroke victims, opportunity to improve the immunization status of his patients, for cautioning against the dangers of poisons left around the home within reach of toddlers, by cautioning families about prevention of accidents, by dealing with malnutrition among aged patients, by showing concern about polluted wells on the farms of rural patients, and by recognizing emotional danger signs among teenage patients. In order for a physician to become preventive medicine oriented, Hillboe suggests that he must reorganize his activities, his office arrangements, his priorities and his appointments. This requires that he truly run his practice and not let his practice run him. A well-run practice that actu-

ally permits a physician to apply preventive medicine does not just happen. It must be forged from the physician's own experiences and tempered by his own determination to build a practice that meets his highest ideals. He must give priority to his patients' needs and not just their demands.

By improving and applying preventive techniques, the physician can serve his patients better, enlarge the scope of his practice and contribute effectively to his community's health. He should find the combined practice of preventive and therapeutic medicine deeply rewarding.

Which physician should have responsibility for initiating and for placing emphasis on preventive medicine? Although it is practiced by pediatricians and to a certain degree by internists the greatest responsibility in preventive medicine should be for the family physician. Indeed I believe it is the responsibility of the Departments of Family Medicine in the medical schools of the United States to teach the concepts of preventive medicine in all its aspects in family practice, in rural health care, in urban health care, and in all the community health projects or programs which many Departments of Family Medicine's provide for students and residents. Perhaps each Department of Family Medicine should develop special sections to emphasize preventive medicine in health care delivery. As Dr. William Stewart recently stated, "it seems obvious that if we as health professionals are going to have an impact on the causes of mortality in our patients in the future, we are going to have to become much more involved in patient education and in attempts to change the lifestyles of our patients. Medical education currently and in the past has been devoted almost exclusively to diagnosis and treatment of disease. As family physicians, we should be in the forefront in helping to educate our patients to live healthier more productive longer lives. In order to accomplish this, we will need to develop methods for bringing about changes in the lifestyles and human behavior."⁵

References

1. Leavell, H.R. and Clark, E.G.: What is Preventive Medicine? In Preventive Medicine for the Doctor in his Community. Leavell, H.R. and Clark, E.G., editors McGraw-Hill Book Company, New York, 1965 pp. 7-13.
2. Hillboe, H.E.: Preventive Medicine, Public Health and the Physician in Preventive Medicine, Hillboe, H.E. and Larimore, G.W. Editors W.B. Saunders Co., Philadelphia 1965, pp. 3-12.
3. Richmond, J.B.: Healthy People, The Surgeon General's Report on Health Promotion and Disease Prevention. DHEW (PHS) Publication No. 79-55071 U.S. Government Printing Office, Washington, D.C. 1979.
4. LaLonde, M.: A New Perspective on the Health of Canadians, Information Canada, Ottawa, 1975.
5. Stewart, W.L.: A Major Role for Family Medicine in the 1980's, J. Fam. Pract. 11:325, 1980.

- Dr. Schulkind, Departments of Community Health and Family Medicine, University of Florida, College of Medicine, Gainesville 32610.

When
Impotence
is due to androgenic deficiency.

Android 5^{Buccal} / 10^{mg} / 25^{Oral} mg

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to endrogen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

Write for new brochure: blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West South Street, Los Angeles, California 90057



An apple a day won't keep alcoholism away!

The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

Do you have a patient who needs this kind of help? You probably do because the illness is sneaky. For more information and guidelines on how to identify these patients, write to us.

Willingway Hospital

311 JONES MILL ROAD
STATESBORO, GA. 30458

(912) 764-6236

J.C.A.H. ACCREDITED



Leadership

**It took time to achieve it
It takes dedication to keep it**

Purepac became the largest generic drug manufacturing facility in the United States by providing high quality generic pharmaceuticals at the lowest possible cost. We know that to be on top tomorrow, we've got to stay a few steps ahead today. Here are some of the steps we've already taken:

- ▶ **Full-time Medical Vice President with Supporting PhD Staff**
- ▶ **ANDA/Patent Review Departments**
- ▶ **State Formulary Manager**
- ▶ **Regulatory Affairs Department**
- ▶ **Comprehensive Advertising and Marketing Support Programs**

It took Purepac 50 years to achieve this leadership position. And we're determined to provide you with even more quality products and dedicated services in the next 50 years.



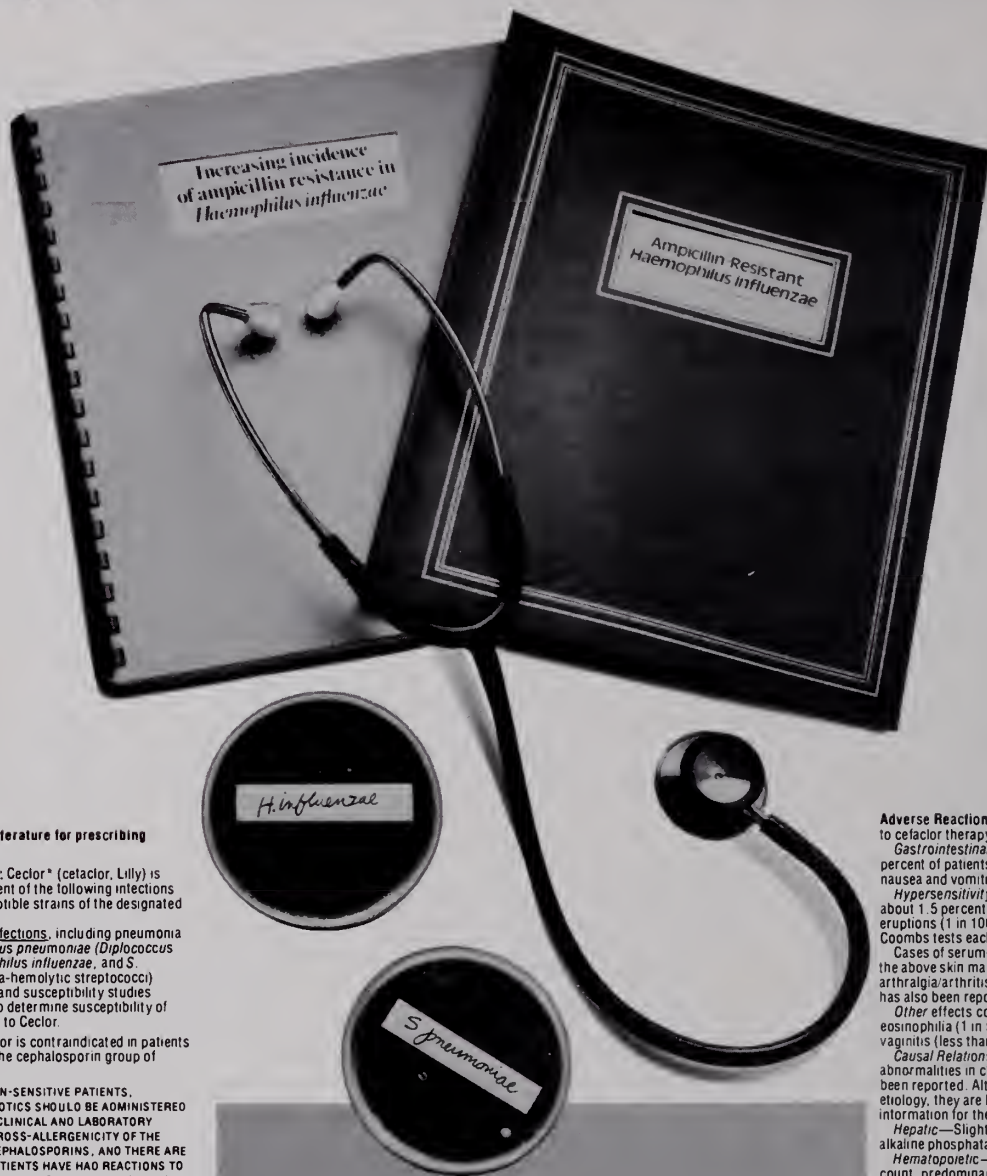
PUREPAC PHARMACEUTICAL CO.

Division of Kalipharma, Inc., Elizabeth, N.J. 07207

1930-1981

Celebrating over 50 years of industry leadership.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceflor* (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceflor.

Contraindication: Ceflor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS. CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceflor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin testing is performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceflor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceflor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceflor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceflor.⁷

Ceflor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below. **Gastrointestinal** symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [1030800]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceflor* (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
3. Antimicrob. Agents Chemother., 13: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.



100081

K⁺ **chLORide: wax** **maTRIX**

SLOW-RELEASE TABLETS 10 mEq



KLOTRIX[®]
**(POTASSIUM
CHLORIDE)**

MeadJohnson
PHARMACEUTICAL DIVISION

ORGANIZATION



**Sanford A. Mullen, M.D.
105th President
Florida Medical Association**

105th President of FMA

Sanford A. Mullen, M.D.

Clyde M. Collins, M.D.

Should there be any truth in the old saw, "If you want work well done, select a busy man", then the affairs of organized medicine in Florida will continue in good hands as transfer of leadership occurred when the president's gavel was passed to Sanford Allen Mullen at the close of the Annual Meeting last month. Becoming the 105th President of the Florida Medical Association, he merely repeated a habit he has been doing over and over for some 40 years. During this time, he has been president, chairman or a leader of just about every organization to which he has belonged.

Born in Tampa January 16, 1925, his family moved to Jacksonville where he attended local schools, impressed his teachers and made friends, many of whom are today's leaders in Jacksonville's professional and business organizations. Elected by his classmates as one of the 10 outstanding graduates of the Robert E. Lee High School Class of 1943, he was recognized as possessing many qualities of the ideal student including scholarship, leadership and personality. Showing versatility, he played on the basketball team, was on the editorial board of the school annual, a member of the band and orchestra, was promoted to Lt. Col. in the Cadet Corps and assumed a leading role in the senior play.

Named for his maternal grandfather, a president of what was then called the Florida State Dental Society, and having a great great uncle who was one of the founders of Mercer College, it appeared predestined that medicine was to be his vocation and that this was to be the school to start him toward that goal.

At the end of his first year, he was voted the outstanding freshman and elected to the Phi Eta Sigma freshman scholastic society. Sometime that year, he began noticing a cute coed in his biology lab. Apparently they soon began going steady, he as editor of the weekly newspaper, and she as his star reporter. At Mercer, he became an ATO, served as president of Blue Key Honor

Society, and edited the college yearbook. Completing his pre-medical requirements in 1945, he traveled to Columbia Physicians and Surgeons to study medicine in September. Persuaded that coed that there was romance, glamour and excitement in the life of a wife of a medical student in New York City, Minnie Lucille Woodall and Sanford were married during the Christmas holidays and moved to the big city where they lived for four years. Taking a straight medical internship at Grady Memorial Hospital in Atlanta, he began his pathology training there only to have it interrupted by the Korean War. Serving in the U.S. Navy Medical Corps, he was sent to the war zone and, on loan to the Army, became one of the few Navy medical officers to earn the coveted Army Combat Medical Badge for active duty with an infantry battalion. Returning from military duty, he completed his anatomical pathology training at Grady and then went to the University of Minnesota where he spent two years to attain his boards in clinical pathology.

Assuming a position as associate pathologist at St. Vincent's Hospital in Jacksonville in 1956, he found this too confining and opened his own office for the private practice of pathology in 1958, which he has continued to the present. He was elected Director of the Jacksonville Blood Bank in 1966 and was made the executive vice president and medical director in 1970. Since that time, he has continued in all these positions in addition to his many activities among charitable agencies, civic clubs and organized medicine. Co-chief of the Department of Pathology at University Hospital of Jacksonville, he is also a Clinical Professor of Pathology of the University of Florida. In 1973, he was the recipient of the A. H. Robins Award for Outstanding Community Service by a physician, presented by the Florida Medical Association. Programs of the Duval County Medical Society the next year when he was president, reflected these many interests as he tried to reveal to its members the culture and worthwhile values of non-medical affairs and activities. A founding member of FLAMPAC, chairman of two Florida Medical Association councils and any number of committees, he served as Vice-Speaker and Speaker of its House of Delegates to demonstrate his talents and diversified concerns. He is serving or has served on the

The Author

CLYDE M. COLLINS, M.D.

Dr. Collins is a surgeon and serves as Medical Director for the Methodist Hospital Hospice, Jacksonville.

Board of Directors of the Arthritis Foundation, the Northeast Florida Heart Association, the Kidney Foundation, the American Red Cross, the Jacksonville Zoological Society, Rotary, Jacksonville Area Chamber of Commerce and the Jacksonville Symphony, but these are only a small segment of his accomplishments for his curriculum vitae extends to eight and one-half typewritten pages.

A voracious reader, he has a large collection of records of big band music including Glenn Miller and Tommy Dorsey but he also enjoys classical music as well. Stacked away somewhere in his home is a complete file of the Florida Medical Association Delegates' Handbooks from 1964 to the present, which he began compiling the year he first served as delegate from Duval County. He enjoys golf but this is one activity he has slighted for he rarely gets to play more than twice a year. Several times selected as one of the 10 best dressed men in Jacksonville, he is so well organized that he needs to shop for clothes only twice a year, always at the same store.

Living in a beautiful home on prestigious Yacht Club Road, Minnie and Sanford are the proud parents of three sons, all of whom have attended Mercer and all of whom have become ATO's there. Apparently at home enough to assert this kind of influence on his sons, he also has the distinction of having Sanford Allen, Jr., finish the University of South Florida Medical School and begin a pathology residency at Bowman Gray University. Middle son Henry graduated from Mercer and is starting his own construction company in Jacksonville, while Michael, the youngest son, completes studies at Mercer where he served as ATO President.

Years ago a wise man observed, "Reading maketh a full man, conference a ready man and writing an exact man". So is our new president a compleat leader, an inspiration for each of us to emulate and to follow.

- Dr. Collins, 580 W. 8th St., Suite 6015, Jacksonville 32209.

Acknowledgement

During the past year *The Journal* has been fortunate in having a cadre of professionals who have been willing and very able to offer opinions, advice and suggestions which have contributed to the continuing excellence of the publication.

Through the unselfish donation of time and energy

these people have reviewed scientific articles, researched topics of current interest to the medical community, offered constructive criticism and advice, produced written material and even procured or created artwork. To these exceptional individuals we would like to offer our sincere gratitude for their efforts.

Neil Abramson, M.D.
John E. Adams, M.D.
Nicholas G. Alexiou, M.D.
Donald O. Alford, M.D.
Carl E. Andrews, M.D.
Vernon B. Astler, M.D.
Henry J. Babers Jr., M.D.
John C. Babka, M.D.
Mr. John A. Baker
William G. Baker Jr., M.D.
Eduardo Bancalari, M.D.
Lewis A. Barnes, M.D.
Thomas D. Bartley, M.D.
Ferdinand F. Becker Jr., M.D.
Roy H. Behnke, M.D.
Charlotte M. Behrman, M.D.
Barkley Beidleman, M.D.
Marvin S. Berk, M.D.
Hal G. Bingham, M.D.

Larry H. Birch, M.D.
Harvey Blank, M.D.
A. Jay Block, M.D.
Hollis G. Boren, M.D.
James L. Borland, M.D.
Irvin Boruchow, M.D.
Pierre J. Bouis Jr., M.D.
J. Bourgiogenie, M.D.
Carl D. Brannan, M.D.
Rufus K. Broadaway, M.D.
Ivan W. Brown, M.D.
Matthew J. Bulfin, M.D.
Gerald E. Byrne, M.D.
Lynn P. Carmichael, M.D.
Frank Carrera III, M.D.
Nicholas Cassisi, M.D.
Elayne E. Cassisi, M.D.
William W. Cleveland, M.D.
Benjamin M. Cole, M.D.

John A. Coleman Jr., M.D.
Clyde M. Collins, M.D.
John P. Collins, M.D.
James K. Conn, M.D.
Richard G. Connar, M.D.
Thomas M. Constantine, M.D.
C. Richard Conti, M.D.
Robert J. Cummings Jr., M.D.
John Cunio, M.D.
Melvin C. Dace, M.D.
O. William Davenport, M.D.
William B. Deal, M.D.
Jorge Deju, M.D.
Sergio A. DeLamerens, M.D.
Charles T. Dellinger, M.D.
Mr. James E. Deming
Robert P. DerHagopian, M.D.
Richard C. Dever, M.D.
J. Lee Dockery, M.D.

Charles K. Donegan, M.D.
 Edgar End, M.D.
 William F. Enneking, M.D.
 Pablo Enriquez, M.D.
 Carl E. Fabian, M.D.
 Emmet F. Ferguson Jr., M.D.
 Lee A. Fischer, M.D.
 Waldo Fisher, M.D.
 Joseph C. Flynn, M.D.
 Rudolph J. Frei, M.D.
 M. Felix Freshwater, M.D.
 Jaime L. Frias, M.D.
 Leonard T. Furlow Jr., M.D.
 James C. Garlington, M.D.
 Eric F. Geiger, M.D.
 Thomas O. Gentsch, M.D.
 Charles H. Gilliland, M.D.
 Howard Golden, M.D.
 Allan L. Goldman, M.D.
 Arthur J. Gosselin, M.D.
 Melvin Greer, M.D.
 Thomas H. Greiwe, M.D.
 Clifford R. Guy, M.D.
 Mutaz B. Habal, M.D.
 T. Wallace Hahn, M.D.
 Charles P. Hayes, M.D.
 Allan Herskowitz, M.D.
 John Hoche, M.D.
 Richard S. Hodes, M.D.
 Howard P. Hogshead, M.D.
 Rufus M. Holloway, M.D.
 Troy Hutchinson, M.D.
 Thomas G. Jenkins, M.D.
 James R. Jude, M.D.
 Maurice Jurkiewicz, M.D.
 Gerard A. Kaiser, M.D.
 Bernard L. Kaye, M.D.
 Norman M. Kenyon, M.D.
 Herbert D. Kerman, M.D.
 R. Taylor King, M.D.
 William C. Kohler, M.D.
 Nelson H. Kraeft, M.D.
 John C. Kruse, M.D.
 Sidney Levin, M.D.
 Bernard S. Linn, M.D.
 William A. Little, M.D.
 Leif A. Lohrbauer, M.D.

Charles S. Mahan, M.D.
 Asher Marks, M.D.
 Donald Mars, M.D.
 Calvin W. Martin, M.D.
 Theodore J. Marshall, M.D.
 Joseph G. Matthews, M.D.
 Joel W. Mattison, M.D.
 Laudie E. McHenry, M.D.
 A. Lee Messer, M.D.
 Robert K. Middlekauff, M.D.
 D. Ralph Millard, M.D.
 Robert H. Miller, M.D.
 Jerome H. Modell, M.D.
 Mrs. Connie Moore
 John W. Moore, M.D.
 Marcus M. Moore, M.D.
 Robert C. Moore, M.D.
 Bernard L. Morgan, M.D.
 Dolores A. Morgan, M.D.
 George A. Morris, M.D.
 Sanford A. Mullen, M.D.
 Louis C. Murray, M.D.
 George A. Neder Jr., M.D.
 Henry E. Newman, M.D.
 Donald G. Nikolaus, M.D.
 Michael A. Nocero, M.D.
 Ward D. Noyes, M.D.
 Gerald N. Olsen, M.D.
 Joseph Ostroski, M.D.
 George S. Palmer, M.D.
 Emanuel M. Papper, M.D.
 W. Harold Parham, D.H.A.
 Jonatha O. Partain, M.D.
 Edward Pedrero Jr., M.D.
 Luis M. Perez, M.D.
 Philip B. Phillips, M.D.
 Michael J. Pickering, M.D.
 C. O. Plyler, M.D.
 E. Charlton Prather, M.D.
 Leon D. Prockop, M.D.
 Fredric W. Pullen II, M.D.
 Dennis F. Pupello, M.D.
 Michael R. Redmond, M.D.
 Albert L. Rhoton, M.D.
 James F. Richards, M.D.
 Allen W. Root, M.D.
 David L. Sall, M.D.

Thomas G. Sawyer, M.D.
 Peretz Scheinberg, M.D.
 Lees M. Schadel Jr., M.D.
 Gerold L. Schiebler, M.D.
 Roger G. Schnell, M.D.
 George C. Schwarz, M.D.
 Meredith L. Scott, M.D.
 Robert C. Seelman, M.D.
 Guy T. Selander, M.D.
 Douglas R. Shanklin, M.D.
 Roger T. Sherman, M.D.
 Dana L. Shires Jr., M.D.
 George T. Singleton, M.D.
 John W. Snow, M.D.
 Edward W. St. Mary, M.D.
 Louis B. St. Petery Jr., M.D.
 Robert G. Steele, M.D.
 Franz H. Stewart, M.D.
 William M. Straight, M.D.
 James N. Sussex, M.D.
 James L. Talbert, M.D.
 W. Jape Taylor, M.D.
 Mrs. Pat Thames
 Thomas B. Thames, M.D.
 Chester Thompson, M.D.
 Mr. John Thrasher
 Robert H. Threlkel, M.D.
 Jerrold A. VanDyke
 Dick L. VanEldik, M.D.
 L. H. S. Van Mierop, M.D.
 F. Norman Vickers, M.D.
 Benjamin Victorica, M.D.
 Joseph C. Von Thron, M.D.
 Frederick Q. Vroom, M.D.
 James W. Walker, M.D.
 Donald E. Warren, M.D.
 H. Warner Webb, M.D.
 Roy Weiner, M.D.
 George H. Welch, M.D.
 Edward R. Westmark, M.D.
 Myron W. Wheat, M.D.
 Jean B. Williams, M.D.
 Governor M. Witt, M.D.
 Bruce Yergin, M.D.
 Gordon Zubrod, M.D.



Richard G. Connar, M.D., of Tampa . . . was recently appointed to the Liaison Committee on Medical Education representing the AMA. The committee is involved in the accreditation process of all American and Canadian medical schools. In addition, Dr. Connar currently serves as vice chairman of the AMA Council on Medical Education, and recently completed a six year term representing the AMA on the Liaison Committee on Graduate Medical Education.

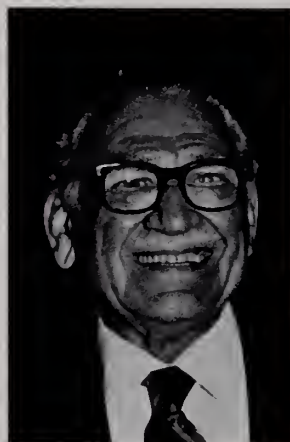
The 1981 graduating class . . . at the University of Florida College of Medicine has honored **Craig S. Kitchens, M.D.,** with its Hippocratic Award for Teaching Excellence.

Representing the class, **Steven Kraft** described Dr. Kitchens as "an ideal teacher, physician, researcher and friend" who is "truly in his element, whether with students, at a conference, presenting a lecture or taking care of a patient."

Dr. Kitchens, a lifelong resident of Gainesville, graduated from the College of Medicine in 1970 and currently serves as Associate Professor of Hematology and Assistant Professor of Pathology.

Initiated by the Class of 1969, the Hippocratic Award is presented to the College of Medicine faculty member who the students believe best embodies the ideals of Hippocrates in patient care and teaching.

Perry A. Sperber, M.D., of South Daytona Beach . . . was presented an Award of Merit at the April meeting of the American College of Allergists in Washington, D.C. Dr. Sperber, now retired, was honored for his contributions to the field of allergy, which included 25 articles, three books and drug research.



Dr. Selinsky

Herman Selinsky, M.D., of Miami . . . was honored on the occasion of his 80th birthday by the South Florida Psychiatric Society, an organization which he helped found. Dr. Selinsky, board certified in psychiatry and neurology, opened his practice in Miami in 1946 as one of a handful of practitioners in a city which now has over 250 psychiatrists.

Dr. Selinsky is credited with having played a key role in the development of the Florida Mental Health Association and its Miami chapter, and in the organization of the Department of Psychiatry when the University of Miami School of Medicine was founded in 1954. He has served as a Clinical Professor in that Department since 1955.

Patricia Pound Barry, M.D., of Tampa . . . has been awarded a five year grant in excess of \$250,000 by the National Institute on Aging. Dr. Barry is Assistant Professor/Director, Division of Geriatric Medicine, Department of Medicine, University of South Florida College of Medicine, and is Clinical Services Director of the USF Suncoast Gerontology Center for Health and Long-term Care. The grant will be used to improve the quality of curricula in geriatrics and to foster research and careers in the field of aging.

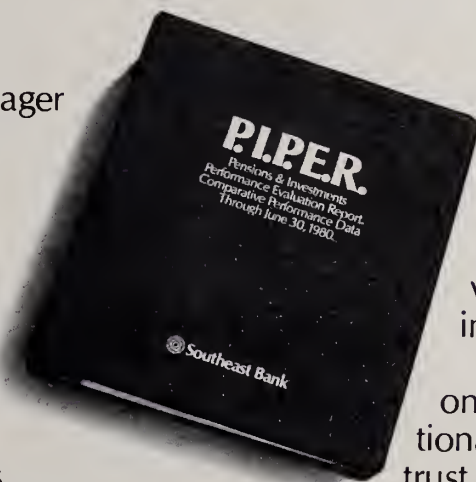
The P.I.P.E.R. report tells you how well your pension plan is being managed. Which is why you've probably never heard of it.

Only one equity fund manager in Florida is likely to call your attention to P.I.P.E.R.

Southeast Bank.

Because no other Florida bank, insurance company or trust company was evaluated as highly by this well-recognized rating service.

In analyzing the performance of 190 major banks and insurance companies all over the U.S., P.I.P.E.R. (Pension and Investment Performance Evaluation Report) rated Southeast in the top 20%. What's more, P.I.P.E.R.



noted that our rate of return was an outstanding 18.3% over the past two years.

Clearly, Southeast is not only the largest bank in Florida, we are also the best in the State in managing trust assets.

Call us for more information on the P.I.P.E.R. report and additional information on the kind of trust services we provide.



Southeast Bank
You can count on us.®

Member FDIC

Bradenton (813) 748-4262 • Deerfield Beach (305) 421-2200 • Fort Lauderdale (305) 561-7942 • Fort Pierce (305) 464-0050
Jacksonville (904) 358-7752 • Largo (813) 585-8558 • Miami (305) 577-3784 • Naples (813) 261-5225
New Smyrna Beach (904) 428-2401 • Orlando (305) 843-4000 • Riviera Beach (305) 848-7232 • Sarasota (813) 953-8137

**When painful spasm
is the presenting
symptom...**

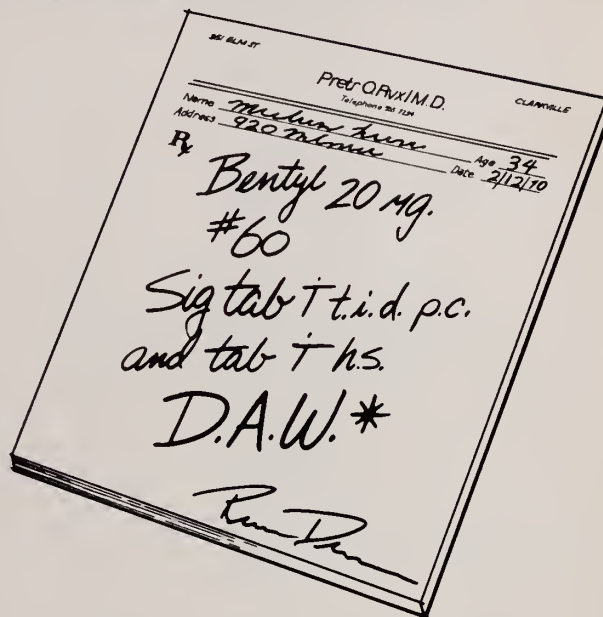


...in the functional bowel/irritable bowel syndrome[†]

be sure to specify

Bentyl[®]
(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injectable



**D.A.W.-Dispense as written*

because:

Bentyl passes these tests for product integrity.

- ⊗ The Bentyl molecule is a product of original Merrell research.
- ⊗ At Merrell, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊗ Bentyl bioavailability of tablets, capsules, syrup and injectable.
- ⊗ The bioequivalence of the oral dosage forms permits a choice of tablets, capsules, or syrup that satisfies patient's dosage preferences.
- ⊗ Pharmacologic effect in the distal colon compared to placebo^{††} shows how Bentyl affects abnormal motor activity in the irritable colon patient.[†]

[†]This drug has been classified "probably" effective for this indication.

Merrell

^{††} In the experiments that showed significant pharmacologic effect, the dose of Bentyl used was 50 mg. I.M., which is higher than that permitted in the labeling. This dose was deemed justified since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level that occurs after a single 50 mg. I.M. dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy), obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Oilule with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NDT FOR INTRAVENOUS USE.

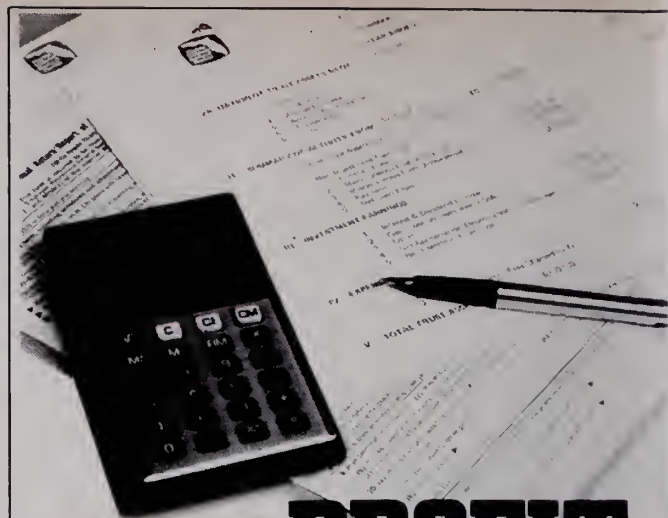
MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 16370 or
TAYLOR PHARMACAL COMPANY
Decatur, Illinois 62525 for
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Merrell

O-6546 (Y115C) MNQ 442



PROFIT FROM OUR EXPERIENCE

For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

We specialize in attaining the results that you require from your account in the areas of:

● **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.

● **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.

● **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

PEOPLE WHO KNOW HOW.

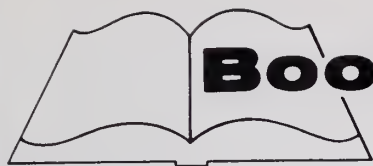
Florida National Trust Services

214 Hogan Street

Jacksonville, Florida 32231

Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC



Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

Maybe He's Dead and Other Hilarious Results of New York Magazine Competitions, by Mary Ann Madden, 274 Pages. Price \$5.95. Random House, New York, 1981.

If you like puzzles and word games from the "New York Magazine" competitions, you might like this collection by Mary Ann Madden, their "competitions" editor.

What I should have said/what I said

- 1) Look, there is a lot of traffic, and he is probably stuck in a meeting all day and didn't get your message, or he'd have called. I am sure there's nothing to worry about.
- 2) Maybe he's dead.
- 1) You are having a baby, how wonderful!
- 2) Who is the father?

Answer Game. You supply the question to the answer that is given.

A. Alexander Pope.

Q. What drink contains brandy, cream and holy water?

A. Remember the Alamo.

Q. What were the last words of the customer who wanted ice cream with his pie?

A. Bullpen.

Q. What is another name for a press agent's ballpoint?

Mind Reading

Or, 1) What was said, 2) What was thought.

- 1) The whaling prints are charming, I love the nautical wallpaper, and the bunk bed is just adorable.
- 2) How could she have thought I meant the actual little boy's room?
- 1) And this button summons Secret Service people.
- 2) And this wastebasket is for your peanut shells.

FNV

Practical Gastrointestinal Endoscopy, by Peter B. Cotton, M.D. and Christopher B. Williams, B.M. 185 Pages. Price \$36.50. Blackwell Scientific Publications, Oxford. 1980.

This well written book achieves its goal of discussing the major aspects of gastrointestinal endoscopy. The 12 chapters include diagnostic and therapeutic upper gastrointestinal endoscopy, ERCP, sphincterotomy, colonoscopy and polypectomy. There are chapters on the function of the endoscopy assistant, documentation and teaching.

This book is illustrated with multiple diagrams which greatly enhance its instructive value.

Also included is a helpful list of addresses for supplies and teaching materials as well as a well chosen bibliography.

This text can be highly recommended both for the experienced endoscopist as well as the student. This book has a rightful place in the hospital medical library, gastroenterology laboratory and in the library of the practicing gastrointestinal endoscopist.

FNV

Colorectal Cancer: Prevention, Epidemiology, and Screening, Sidney J. Winawer, David Schottenfeld, Paul Sherlock, Editors. 410 Pages. Price \$39.50. Raven Press, New York, 1980.

This book is a summary of the International Symposium on Colorectal Cancer held in New York in 1979. Fifty papers covering various aspects of the subject are included. This somewhat encyclopedic work suffers some of the problems of a multi-author book—variation in style and duplication of some material. The individual papers, however, are usually succinct and include pertinent references. Another disadvantage,

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

**Each CEREBRO-NICIN® capsule
contains:**

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



perhaps, is that another symposium has been held and presumably another book of similar type will ensue.

The list of approximately 100 authors includes outstanding investigators in the world of gastroenterology. These include Thomas Almy of Dartmouth, Basil Morson of London, Warren Nugent of the Lahey Clinic, Norman Zamcheck of Boston City Hospital and Jerome Waye of Mt. Sinai Hospital, New York.

The book will find its usefulness to physicians searching for specific material on colorectal cancer. This book would be a welcome addition in the institutional medical library. However, I doubt that this would be of significant lasting interest to the practicing physician for his personal library.

FNV

**This publication
is available in microform.**



University Microfilms International

Please send additional information

Name _____
Institution _____
Street _____
City _____
State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

JULY

Cardiac Rehabilitation, July 24-25, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood 80112.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, (7th Annual Review Course), Aug., Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

ECG Interpretation and Arrhythmia Management, August 28-30, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood 80112.

SEPTEMBER

Department of Surgery Meeting, Sept. 8, St. Joseph Hospital, Port Charlotte. For information: Jane P. Ontog, R.N., M.S., 601 N.E. Harbor Blvd., Port Charlotte 33952.

Indication and Implications of Office Pulmonary Function Testing, Sept. 17, Ft. Cooper Station Restaurant, Inverness. For information: C. J. McGrew Jr., M.D., 2875 Keysville Avenue, Spring Hill 33526.

OCTOBER

X-Ray Interpretation for the Primary Care and Emergency Physician, Oct. 1-4, St. Petersburg. For information: Sharon G. Llera, Administrative Assistant, Professional Services, Emergency Medical Services Assistants, 1400 66 Street, Suite 260, St. Petersburg 33710.

Parenting and Reparenting, Oct. 2, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Fort Walton Beach 32548.

Evaluation and Therapy of Shock and Drowning, Oct. 15, Ft. Myers. For information: Irwin J. Kash, M.D., Chairman, Department of Pediatrics, 3949 Evans Avenue, Suite 207, Ft. Myers 33901.

NOVEMBER

Clinical Management of Coronary Disease and Exercise Testing, Nov. 5-8, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood, CO 80112.

The ABC's of Viral Hepatitis, Nov. 19, Ft. Cooper Station Restaurant, Inverness. For information: C. J. McGrew Jr., M.D., 2875 Keyville Avenue, Spring Hill 33526.

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on
standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



COLEGIO MEDICO CUBANO LIBRE
THE CUBAN MEDICAL ASSOCIATION IN EXILE
ANNOUNCES THE
SIXTH INTERNATIONAL CUBAN
MEDICAL ASSOCIATION CONGRESS
1981

To be held at
The Sheraton Bal Harbour Hotel, Miami Beach
June 30 - July 4, 1981

Superior Interesting Scientific Program
Guest Faculty Includes Prominent Doctors from the United
States, Various Latin American Countries and Europe

The Congress has been approved for 40 hours, Category I, American Medical Association Recognition Award, 40 Mandatory Hours from the Florida Medical Association and 40 Prescribed Hours, Category I, from the American Academy of Family Physicians.

DAILY SCIENTIFIC SESSIONS

Morning Hours — Plenary Sessions — 8:00 a.m. to 1:00 p.m.
Afternoon Hours — Different Specialties — 2:00 p.m. to 6:00 p.m.

REGISTRATION FEES

\$120.00 before June 15, otherwise \$130.00

A LIVELY AND VARIED SOCIAL PROGRAM WILL BE OFFERED

AND THE

POST CONGRESS

TO

SOUTH AMERICA — BRAZIL — ARGENTINA — CHILE — PERU

JULY 5 TO JULY 22

ADDITIONAL OPTION TO VENEZUELA JULY 22 - 25

For Information and Registration Please Write or Call:

Cuban Medical Association
213 Aragon Avenue — P.O. Box 341016
Coral Gables, Florida 33134
Telephone: (305) 446-9902

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

MEDICAL OPHTHALMOLOGIST wanted for busy practice. No refraction or contact lens fitting. Ideal location in East Coast of Florida. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

WELL TRAINED Family Practitioner or Internist needed to join staff of a Family Medical Center in Jacksonville, Florida. Excellent opportunity for professional and economic growth. Respond with CV to: Susan Masterson, Emergency Medical Services Associates, Inc., 8200 W. Sunrise Boulevard, Building C, Plantation, Florida 33322, or phone (305) 472-6922.

SURGEON — General, Vascular, Thoracic — Non-cardiac — needed as independent or associate in small town bordering Orlando. Send CV and references to C-1044, P.O. Box 2411, Jacksonville, Florida 32203.

LOCUM TENENS — Diagnostic Nuclear, Ultrasound, Radiology Department. Coastal Northeast Florida — Summer and/or Fall months — May lead to association. Contact: J.L. Castillo, M.D., P.A., Post Office Drawer N, Fernandina Beach, Florida 32034.

GENERAL INTERNIST or General Practitioner wanted for a practice which consists primarily of general Internal Medicine, but also includes some family practice and industrial medicine. The

position would be ideal for an American well trained physician who is seeking good hours, excellent working conditions, is willing to work hard and yet wants a substantial amount of free time. Please send C.V. and recent photo to: Jan A. Becker, M.D., 727 Vassar Ave., Orlando, Florida 32804.

FLORIDA — Aggressive group, fee-for-service, malpractice, group health insurance, teaching, EMS, opportunity for advancement. Contact Steve Watsky, M.D., 707 40th Street West, Palmetto, Florida 33561, (813) 722-1722 or P. Fagan Jr., M.D., Post Office Box 9639-FL, Marina Del Rey, California 90291, (213) 822-1312.

LOCUM TENENS — COMP-HEALTH. Our medical group can provide a well qualified physician to cover your practice in your absence. For information, please write or call T.C. Kolff, M.D., Comprehensive Health Systems, Inc., 175 West 200 South, Suite 2003, Salt Lake City, Utah 84101, (801) 532-1200.

EMERGENCY MEDICINE opportunities throughout Florida: Directorship and clinical positions available to career-oriented emergency physicians in central and coastal areas. Excellent compensation, paid professional liability insurance, flexible scheduling to be awarded to physicians chosen. For details send credentials in complete confidence to Mary Obsitnik, 9100 Purdue, Suite 119, Indianapolis, IN 46268; or call collect (317) 875-7518.

MULTISPECIALTY GROUP: Recruiting for positions in pediatrics, ENT, general/vascular surgery with board eligibility or certification in thoracic surgery and orthopedics. Qualified candidates may notify Administrator, Palm Beach Medical Group, 705 North Olive Avenue, West Palm Beach, Florida 33401.

CHIEF OF HEALTH SERVICES, Florida Department of Corrections: Opening for Florida licensed physician, preferably with 4-5 years administrative experience managing a health delivery system composed of multiple institutions. Salary competitive depending on qualifications. Send vita to Recruiting Coordinator, Florida Department of Corrections, 1311

Winewood Blvd., Tallahassee, Florida 32301.

FLORIDA — Family Physicians wanted for non-profit, multi-specialty group. Board certified or board eligible. Positions available in July 1981. Excellent compensation; no overhead. Contact: Administrator, MCMC, 8190 Okeechobee Blvd., West Palm Beach, Florida 33411. (305) 684-1119.

FAMILY PRACTICE ASSOCIATE — Preferably Diplomate AAFP, to assume Hospital, Nursing Home, Night Calls, as well as Office Practice. 64 year old AAFP physically limited to office practice. Five minutes from two hospitals. Excellent office staff. Former associate leaving mid-June for Residency. Address curriculum vitae to Donald E. Fortner, M.D., 5800 S.W. 73rd Street, South Miami, Florida 33143.

MEDICAL DIRECTOR / FAMILY PHYSICIAN for private, non-profit facility. 50% Administrative — 50% clinical. Minimum five years administrative experience. Available summer 1981. Seek candidate with consumer-oriented philosophy. Contact: Administrator, MCMC, 8190 Okeechobee Blvd., West Palm Beach, Florida 33411, (305) 684-1119.

INTERNIST TO JOIN established partnership practice, Orlando, Florida. Starting July 1981. Curriculum vitae to Internal Medicine Group, 1910 N. Orange Avenue, Orlando, Florida 32804.

RADIOLOGIST wanted for sixteen member, multi-specialty clinic. Diagnostic Radiology position available July 1, 1981. Ideal position for the individual that is ready to slow down. Contact: W. H. Brigman, Administrator, Bond Clinic, P.A., 500 East Central Avenue, Winter Haven, Florida 33880, or call (813) 293-1191.

FLORIDA — Pediatrician, must be Board certified — eligible, to associate with a busy, progressive practice, with excellent hospitals. Attractive and recreational area of Winter Park, and Orlando. Applicants are encouraged to submit a curriculum vitae to: Louis Spinelli, M.D., 100 Perth Lane, Winter Park, Florida 32792.

COUNTY PUBLIC HEALTH DIRECTOR/Administrative and Medical Director for the Public Health Unit of Leon/Wakulla Counties, Florida. Headquarters in Tallahassee, Florida's Capital City. Full range of Public Health programming. Staff of 90; annual budget exceeds \$2,000,000. Florida licensure as a Doctor of Medicine or Doctor of Osteopathy required; and a Master of Public Health Degree and two years of administrative Public Health experience, or certification by the American Board of Preventive Medicine and one year of administrative experience. Excellent fringe benefits. Salary negotiable. Contact: E. C. Prather, M.D., Florida Department of Health and Rehabilitative Services (an equal opportunity affirmative action employer), District Two, 2639 N. Monroe Street, Tallahassee, Florida 32303, phone (904) 487-2546.

FP's NEEDED for ideally located office in north Palm Beach County, (Jupiter-Tequesta area). Also, space for ophthalmologist or dermatologist. Coverage and assistance available. Two open staff hospitals nearby for qualified M.D.'s. Call: (305) 746-2033.

PSYCHIATRIST NEEDED IMMEDIATELY for a full-time position with our Outpatient Program, 15-bed Crisis Stabilization Unit and 90-bed Geriatric Residential Center. Florida license (or eligibility) required. Private practice and consulting opportunity available. Responsibilities include intake diagnosis, treatment and discharge, rotating on-call duty, and outpatient consulting for psychiatric medications. Salary range good. For more information, contact: Personnel Department, Santa Rose County Mental Health and Rehabilitation Facility, Inc., 400 Stewart, N.E., Milton, Florida 32570. EEO.

CARDIOLOGIST wanted in Northeast Florida area to join solo practitioner. Two-D echo, exercise treadmill testing, EKG interpretation, cardiac catheterization laboratories and open heart surgery program available. Immediate opening for a well qualified cardiologist. Invasive or non-invasive. Contact: Box C-1057, Post Office Box 2411, Jacksonville, Florida 32203.

MEDICAL EMERGENCY SERVICE ASSOCIATES (MESA), S.C. Now hiring qualified physicians to staff emergency departments in Florida. MESA offers excellent salary, working conditions, flexible scheduling and fringe benefits, plus the opportunity to join a stable, growing co-

operation dedicated to providing quality emergency medical services. Send your C.V. or telephone: MESA, Florida, Post Office Box 8585, Orlando, Florida 32856 or Ms. Tesla (305) 841-5111, ext. 5898. MESA would like to be a part of your life.

Situations Wanted

GENERAL, COLON AND RECTUM SURGEON, trained in Colonoscopy, Board eligible, 35, seeks position in Florida to practice either one specialty or both. Speaks Spanish fluently. Available October 1981. Contact: Luis F. Espallat, M.D., 1517 Texas Avenue, Homestead AFB, Florida 33039. Phone (305) 257-2870.

versity and broad experience in 800 bed hospital. Certified Anatomic and Clinical Pathology. Desires relocation in Florida. Prefer hospital based or group position in Gulf Coast area. Reply: C-1046, Post Office Box 2411, Jacksonville, Florida 32203.

INTERNIST, BOARD Eligible, Florida licensed. Floridian desires relocation in Florida. University trained; one year clinical pulmonary disease. Academic background. Experience in solo and group practice and corporate medicine. Available about July 1, 1981. For CV and information contact: Harry A. Edwards, M.D., days — (615) 327-2520, evenings — (615) 446-6714. Rt. 2, Box 41, Burns, Tennessee 37029.

PSYCHIATRY: Clinically oriented 34 year old Psychiatrist in successful solo practice with wide consultation experience (including CMHC, Forensic Psychiatry) and contract teaching of F.P. Residents) seeks group practice or interesting consultation opportunities in Miami / Fort Lauderdale. C.V. on request. C-1050, P.O. Box 2411, Jacksonville, Florida 32203.

MEDICAL OPHTHALMOLOGY: 43 year old American Board certified, desires satisfactory position in established practice. Will consider all locations. Curriculum Vitae on request. C-1051, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON with G.I. endoscopy experience interested in trauma. Completed training in 1979. Seeking a surgical group or Multispecialty Clinic. Available September 1981. Will consider organizing multispecialty group. Write: E.C., 3711 Lonniewood Drive, Houston, Texas 77059.

INTERNIST - PULMONOLOGIST, 33, University Hospital trained in Bronchoscopy, I.C.U., P.F.T., Swan-Ganz. Wife physiatrist University trained. Seeking job or practice after July 1981. Reply C-1034, P.O. Box 2411, Jacksonville, Florida 32203.

FAMILY PRACTITIONER, American, 34, with background in Rehabilitation Medicine seeking association or locum tenens in Broward or South Palm Beach County. Excellent references. Reply: L. Creations, Post Office Box 160122, Miami, Florida 33116.

BOARD CERTIFIED GENERAL SURGEON — 36 — solid experience peripheral vascular surgery; four years experience post-residency including three years teaching hospital. Seeks group or partnership. Available October 1, 1981. Contact: S. V. Mazzara, M.D., 251 Labarranca Dr., Solana Beach, California 92075, (714) 481-0240.

BOARD CERTIFIED DIAGNOSTIC RADIOLOGIST — 34 — Solid experience general radiology — ultra sound — mammography. Five years experience including three years teaching hospital. Seeks group or partnership. Available October 1, 1981. Contact: Laure F. Mazzara, M.D., 251 Labarranca Drive, Solana Beach, California 92075, (714) 481-0240.

BOARD CERTIFIED PEDIATRICIAN — 34 years old, seeking practice opportunity in Florida. Medical school at Ohio State. Residency at Akron. Ambulatory fellowship at Cleveland. Four year practice experience. Reply: C-1055, Post Office Box 2411, Jacksonville, Florida 32203.

GENERAL PRACTITIONER, experienced in industrial and occupational medicine. Excellent training in medical centers, with Florida license; seeks position in private clinics, association with multi-specialty group, nursing home and health organizations. Available September 1981. Reply: Post Office Box 8992, Pembroke Pines, Florida 33122.

BOARD CERTIFIED (Family Medicine) Florida license, seeks 40 hour a week job in private clinics, Public Health or nursing homes, also Locum Tenens. Reply: C. C. Barrameda, M.D., 333 N.E. Surrey Street, Port St. Lucie, Florida 33452, Telephone (305) 878-8834.

GENERAL SURGEON, 34, Broad experience, excellent references, relocating to Florida. Seeks immediate practice opportunities leading to partnership with group/solo practice. Particularly interested in combined Internal Medicine/Surgery practice. Prefer medically underserved area. Available August 1981. Reply: S. E. Katz, M.D., c/o Rohr, 319 East 53rd Street, New York, New York 10022, (212) 759-2631.

Practices Available

MEDICAL OFFICE AVAILABLE JULY 1981, 475 Biltmore Way, Coral Gables; 1,000 square feet. All furniture, fixtures and equipment ready for sale intact to lessee. Functional, tasteful office, "ready to go" for specialist or generalist or new physician. Call 443-8767 or 665-1713 after 5.

GENERAL PRACTICE FOR SALE, growing area, Pinellas County; same location 20 years; also, possible association. Gonzalez, M.D., (813) 443-2104 after 7 p.m. or write P.O. Box 1286, Clearwater, Florida 33517.

ESTABLISHED INTERNAL MEDICINE Practice with fully equipped office for sale. Excellent location in North Miami Beach, Florida — near hospitals. Negotiable terms. Reply: C-1053, Post Office Box 2411, Jacksonville, Florida 32203.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

MEDICAL FACILITY downtown Orlando near all hospitals. 1493 feet includes X-ray, exam rooms, etc. Free use of \$60,000 worth of medical equipment. Sacrifice \$900 month. (305) 425-2843 or 351-5885.

OUTSTANDING LOCATION — Professional office space for rent. Multi-specialty building adjacent to modern 225 bed Medical Center emergency room. Contact Post Office Box 4082, Fort Pierce, Florida 33454. Phone: (305) 465-7060.

WEST PALM BEACH: Located in a new, fast developing area, 200 years east of I-95 exit, adjoining The Community Hospital of the Palm Beaches and near St. Mary's hospital. Medical Suites: From 3 to 6 examing rooms, business office, waiting room, and consultation rooms. Storage closets, built-in office desk cabinets, multi drawer work area cabinet with sink, wash basins in each examining room, extensive parking. Contact: Community Professional Building, 2151 45th Street, West Palm Beach, Florida 33407. (305) 842-5023.

SANFORD, FLORIDA — Near new hospital. Will build doctor's offices to suit. 3,500 square feet. Long term lease. For additional information call (813) 971-8503 or write 14910 Lake Forest Drive, Lutz, Florida 33549.

TO SUBLET — Medical office space in prime Medical Office Building. Convenient to St. Joseph's and Women's Hospital, 4700 N. Habana Avenue, Tampa, Florida; 15550 square feet, well partitioned office, four exam rooms, two consultation rooms, lab and business office. Suitable for almost any specialty. Call (813) 877-7434.

LAKELAND, FLORIDA. Medical Office space available in Professional Village; central Florida location. Colleges, retirement community, and industries create interesting environment for practice. 1424 square feet, can be partitioned to suit. Available as rental or purchase as condominium. Contact: Edwin R. Lamm, M.D., (813) 682-3672 or 665-5773* (After May 15, 1981).

BOCA RATON — For rent. Office 1,100 square feet in luxurious Medical Complex in front of Boca Hospital. Contact: Inez F. Jenkins, Realtor, 234 S. Federal Highway, Boca Raton, Florida 33432.

NEW MEDICAL BUILDING for rent in fastest growth area in central Florida, between Orlando and Sanford. Ideal for general practice or pediatrician. Across street from elementary school. All inquires confidential. Reply: Box C-1056, Post Office Box 2411, Jacksonville, Florida 32203.

OTOLARYNGOLOGY PRACTICE — for sale. Active practice in Key West. Fully equipped, for 25% of annual gross. Entering Academics, If practice sells. Contact: William Clark, M.D. (305) 294-6622 or 296-2705.

Equipment

FOR SALE: X-Ray unit complete with tube, fluoro intensifier, Pako dryer, cassettes — all sizes, metal hangers — all sizes, passbox and film bin. R. B. Hanahan, M.D., 1415 Lakeland Hills Blvd., Lakeland, Florida 33801, phone (813) 682-4183.

AUDIOMETRIC BOOTH: Eckoustic Model AB-200 with all options — \$1800.00. SMR equipment: Two SMR Model H Hydraulic treatment chairs — \$400.00 each. Two Model J6AEF equipment cabinets (floor models with suction and pressure) — \$850.00 each. Contact: Charles Tucker, Jr., M.D., 5150 Bayou Blvd., Suite 2F, Pensacola, Florida 32503. (904) 476-3223.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Col, 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Services

DOCTOR, WE KNOW YOUR BUSINESS. With 27 years experience as a hospital administrator and being raised in a Doctor Family, Bill Bishop, FACHA, understands your needs! He specializes in recruitment and placement of doctors in Florida. Bill Bishop and Associates, Inc., Health Care Executive and Physician Search Consultant, 1045 Riverside Ave., Jacksonville, Florida 32204, (904) 388-1551.

Meetings

SNOWMASS/VAIL "MEP" SKI SEMINAR on management Enrichment for the Health Professional: Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or Ski Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and specialist to enrich your life. Seminars comply with IRS rules to make trip expenses deductible for doctor and spouse. For brochure and lodging information contact: M.E.P., An Education Corporation, 906 Cooper Avenue, Glenwood Springs, Colorado 81601; or call (800) 525-3402.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Advertisers

Boots Pharmaceuticals		Merrell-Dow Pharmaceuticals	
F.E.P. Creme,		Bentyl	460
Su-Ton, Twin-K, Twin-K-Cl	422a	Tenuate	422a
Bristol Laboratories		Numismatic Investments of Florida	
Tegopen	420	Investments	414
Brown Pharmaceuticals		Pennwalt Pharmaceuticals	
Cerebro-Nicin	464	Zaroxolyn	462a
Lipo-Nicin	465	Purepac Pharmaceuticals	
Android	450	Generic Drugs	451
Burroughs Wellcome		Reed & Carnrick	
Neosporin Topicals	412	Dilatrate-SR.	462a
Convention Press		Roche Laboratories	
Service	408	Valium	471
Cuban Medical Association in Exile		Limbitrol	406
Meeting	466	Librax	422a
DAC Corporation		Sequoia Group, Inc.	
Service	422	Medical Systems	422a
Florida Medical Foundation		Southeast Banking	
Fruit	418	P.I.P.E.R.	459
Florida National Banks		University of Florida	
Service	462	Meeting	422
Geriatric Pharmaceutical Co.		Wetzel	
Cevi Bid	424	Service	410
Janssen Pharmaceutica		Willingway Hospital	
Vermox	411	Service	450
Eli Lilly & Company		Wyeth Laboratories	
Ceclor	452	Cyclapen-W	414
Mead Johnson		Ativan	418
Klotrix	453	Eguagesic	422a
		Wygesic	422a

Florida Medical Association Officers and Council Chairmen

Officers

Sanford A. Mullen, M.D., Jacksonville, President
 Robert E. Windom, M.D., Sarasota, President-Elect
 Gerold L. Schiebler, M.D., Gainesville, Vice President
 Luis M. Perez, M.D., Sanford, Secretary
 J. Russell Forlaw, M.D., Boynton Beach, Treasurer
 T. Byron Thames, M.D., Orlando, Immediate Past-President
 James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
 Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
 W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
 Louis C. Murray, M.D., Orlando, Legislation
 Charles P. Hayes, M.D., Jacksonville, Health Care Financing
 Joseph T. Ostroski, M.D., Miami, Medical Services
 Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
 Arthur L. Eberly, M.D., Lighthouse Point, Specialty Medicine

OF THE FLORIDA MEDICAL ASSOCIATION INC



THE JOURNAL
JULY 1981 • VOL 68 • NO. 7



PROCEEDINGS ISSUE
Florida Medical Association House of Delegates
April 29-May 3
Diplomat Hotel, Hollywood

CHRYSTAL
1981

2 13 41

Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to decrease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgeable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ®, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

AUG 12 1981

Valium® diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antipsychotics may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications: Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings: Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions: Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions: Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemias, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure: Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

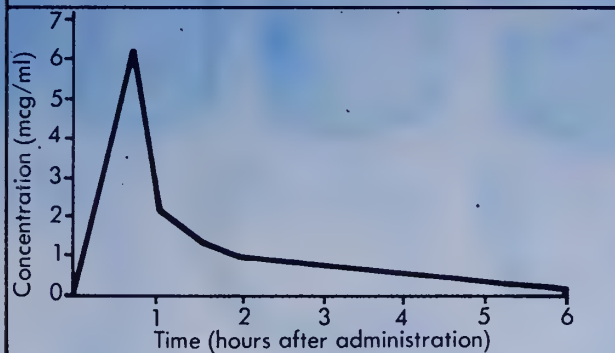
†depending on severity

Wyeth Laboratories
Philadelphia, Pa. 19101

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on $T^{1/2}$ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See important information on facing page.

CYCLAPEN-W®
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

Wyeth Laboratories • Philadelphia, Pa 19101



NEW
NAME



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

JULY 1981 • VOL 68 • NO. 7 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.
E. Charlton Prather, M.D.

Assistant Editors

Francis C. Coleman, M.D.
James K. Conn, M.D.
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
Norman M. Kenyon, M.D.
(from Board of Governors)
Edward Pedrero Jr., M.D.

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Susan L. Milhoan

Consulting Editorial Staff

Fuad S. Ashkar, M.D.	R. G. Lacsamana, M.D.
Thomas D. Bartley, M.D.	Richard F. Lockey, M.D.
Robert L. Batey, M.D.	Philander D. Morgan, M.D.
Pierre J. Bouis Jr., M.D.	George Morris, M.D.
Ms. Deborah B. Wilbur	George A. Neder Jr., M.D.
William T. Branch, M.D.	Richard S. Panush, M.D.
Miguel A. Brito, Jr.	R. A. Penalver, M.D.
Elmer B. Campbell, M.D.	John K. Petrakis, M.D.
Manuel L. Carbonell, M.D.	Phillip B. Phillips, M.D.
Ronald W. Case, M.D.	Michael R. Redmond, M.D.
Louis E. Cimino, M.D.	Albert L. Rhoton, M.D.
Charles Craig, M.D.	James F. Richards Jr., M.D.
R. Jay Cummings Jr., M.D.	Arvey I. Rogers, M.D.
Raul deVelasco, M.D.	William J. Romanos Jr., M.D.
James E. Deming	Lees M. Schadel, M.D.
Pablo Enriquez, M.D.	Frederick W. Schert, M.D.
Robert F. Feltman, M.D.	Guy T. Selander, M.D.
Richard Feinstein, M.D.	Roberto A. Sosa, M.D.
Lawrence M. Fishman, M.D.	John Stone, M.D.
Allan L. Goldman, M.D.	Robert H. Threlkel, M.D.
Henry L. Harrell, M.D.	Benjamin E. Victorica, M.D.
Allan Herskowitz, M.D.	Thomas M. Wiley, M.D.
James T. Howell, M.D.	Charles D. Williams, M.D.
Rubin Klein, M.D.	Frederic C. Wurtzel, M.D.
Karl J. Kramer, M.D.	

Subscription Rate: \$15.00 per year, single copy. \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917: authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

Proceedings

- 509 The Proceedings of the 107th Annual Meeting of the Florida Medical Association, held April 29 — May 3, 1981

Scientific Articles

- 491 Emergency Management of Scuba Diving Accidents
*Barbara B. Tabeling, M.D., and
T. James Gallagher, M.D.*
- 496 Primitive Hypoglossal Artery Associated with Middle Cerebral Artery Aneurysm, A Case Report
*Gaston J. Acosta-Rua, M.D., and
William F. McCormick, M.D.*
- 499 Diagnosis of Intradural Sacral Lipoma and Tethered Cord by Computed Tomography
F. Reed Murtagh, M.D., and Gene A. Balis, M.D.
- 501 A Community-Based Colon and Rectal Cancer Screening Program
Joseph K. Isley Jr., M.D., and Richard B. Akin

Organization

- 587 Impaired Physician Intervention Workshop in Tampa in September

Departments

- 481 President's Page
Medicine and Business
Sanford A. Mullen, M.D.
- 487 Professional Liability Legal Update
- 588 Medical News Around the State
- 591 FMA Auxiliary
Fifteenth Annual Benefit Art Show Winners 1980-1981
- 593 Meetings
- 594 Florida Medical Association, Inc. Officers, Councils and Committees 1981-1982
- 599 Classified Advertising
- 602 Index to Advertisers
- 602 FMA Officers and Council Chairmen

Cover

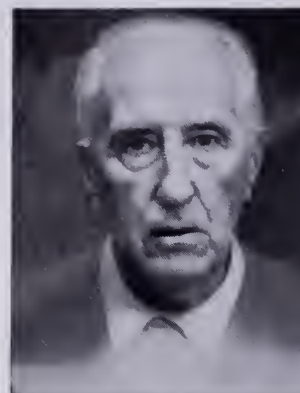
The winner of the Editor's Award in the Fifteenth Annual FMA Auxiliary Benefit Art Show is a photograph by Lee A. Fischer, M.D., of West Palm Beach. The clowns exemplify the Auxiliary's theme, "Get Into The Act". The entire family got into the act for the picture — the clowns are the Fischer children, Adam and Rachel, and their mother made the costumes.

Index to Proceedings

A. H. Robins Award	516	Distinguished Layman's Award	525
Ad Hoc Committee on Impaired Physicians .	564	Election of Officers	584
AMA Delegates	559	Florida Health Data Corporation	583
Board of Governors Report A	544	Florida Medical Foundation	563
Board of Governors Report B	532	Florida Physicians Association	565
Board of Governors Report C	539	General Session	518
Board of Governors Report D	573	House of Delegates	
Board of Governors Report E	579	First House	512
Board of Governors Report F	558	Second House	524
Certificate of Appreciation	528	Third House	569
Certificate of Grateful Recognition	526	President's Address	509
Certificate of Merit	528	Public Relations	559
Council Reports		Reference Committee I	532
Health Care Financing	582	Reference Committee II	538
Judicial	566	Reference Committee III	544
Legislation	575	Reference Committee IV	573
Medical Services	539	Reference Committee V	579
Scientific Activities	534	Remarks of the Speaker	514
Specialty Medicine	535	Speaker's Bureau	562

RESOLUTIONS

81-1	Continuing Medical Education	536
81-2	Bylaws Amendment	567
81-3	Physician Billing for Laboratory Services	579
81-4	National Standardized Immunization Form	540
81-5	Physician's Assistants	540
81-6	Dues Reduction for Semi-Retired Physicians	567
81-7	Special Licensing for Physician Educators and Public Health Physicians	567
81-8	FDA Opinions on Drugs	541
81-9	Installment Payment of Dues	567
81-10	Discriminatory Reimbursement by Medicare	583
81-11	Seating of Delegates	567
81-12	Voluntary Effort	584
81-13	Health Systems Agency Monitoring	568
81-14	Florida Medical Association's Defense of a Lawsuit Against Various Insurance Intermediaries	568
81-15	Limiting the Percentage Charged by Attorneys for Contingency Fees	577
81-16	Workers' Compensation Fee Schedule	584
81-17	Federal Income Tax Deductions for Free Medical Care Rendered to Indigents	578
81-18	Nominations for FMA Elected Offices	568
81-19	Location-Annual Meeting of the FMA House of Delegates	568



Dual-action therapy to enhance mental and physical activity in the elderly.

MENICTM

PENTYLENETETRAZOL 100 mg • NICOTINIC ACID 50 mg

Menic combines the proven effectiveness of cortical stimulation and cerebral vasodilation, reducing mental confusion, faulty memory and negative social behavior often associated with the senility syndrome.

DOSAGE: Two tablets after each meal.

SIDE EFFECTS: Occasionally flushing and pruritus associated with niacin administration.

PRECAUTIONS: Use with caution in patients with low convulsive threshold, focal brain lesions, severely impaired liver function,

peptic ulcer, diabetes, and gall bladder or liver diseases. Niacin may potentiate hypotensive drugs, phenothiazine derivatives and inactivate fibrinolysin.

CONTRAINDICATIONS: There are no known contraindications to Menic.



GERIATRIC PHARMACEUTICAL CORP. 397 JERICHO TURNPIKE, FLORAL PARK, N.Y. 11001
PIONEERS IN GERIATRIC RESEARCH . . . DEVELOPERS AND SUPPLIERS OF CEVI-BID • GAYSAL • ISO-BID

An apple a day won't keep alcoholism away!

The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

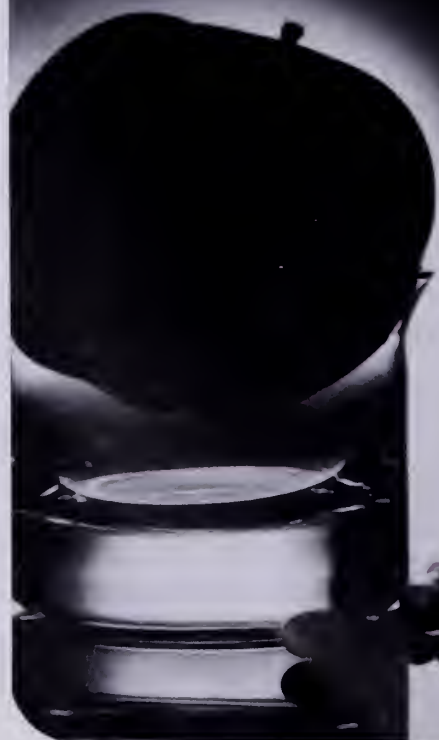
Do you have a patient who needs this kind of help? You probably do because the illness is sneaky. For more information and guidelines on how to identify these patients, write to us.

Willingway Hospital

311 JONES MILL ROAD
STATESBORO, GA. 30458

(912) 764-6236

J.C.A.H. ACCREDITED





President's Page

Medicine and Business

Nearly everyone today is becoming aware that modern medical care has a distinct cost factor. At the present time the cost of health care in the United States has reached the level of approximately 10% of the gross national product (GNP). According to some knowledgeable observers, if the present trend continues, the cost of health care could reach 15% of the GNP by the end of the century.

As the cost of health care has increased, more and more individuals and groups have become interested in it. The news media are devoting a great deal of time to the situation with many analyses of the various factors causing the escalation of health care cost. Legislative and executive branches of government at all levels have become more and more involved in an effort to control costs.

Of course, the problem of increasing costs of health care is not a simple matter. It is highly complex and is intimately involved with the financial problems which our nation faces. Inflation has been a major factor in the rising costs of health care just as it has in the rising costs of almost everything, including our own households.

As responsible members of society, physicians and their families need to become involved in the efforts to control the cost of health care. In becoming involved, physicians must stand on the principle that quality of care cannot be compromised. Physicians must be the conscience of our country's efforts to control the cost of health care.

One of the most important developments in the effort to control health care cost has been the increasing interest of the business community in the cost of health care for their employees. In the past, management has paid little attention to the cost of their health care programs except to be generally aware of the total cost of the program as a part of the fringe benefits which are provided to their employees. This particular fringe benefit has, however, been increasing in cost every year,

frequently at a rate which has become alarming to management. Twenty and thirty percent increases each year have not been unusual.

Business has started studying its health care benefits package with a great deal of interest. They have recognized that it will be difficult to make changes in these benefits which have become established as a part of their contracts with labor. It is obvious that no one would want to reduce the level of benefits which have already been achieved. It is easy to understand why labor has no overwhelming desire to reduce the level of its health care benefits package.

As business has studied the matter of health care benefits, it has become apparent that there has probably been over utilization to at least some degree in most plans. This over utilization is fostered in many instances by the fact that the plan provides first dollar coverage with no co-insurance by the individual beneficiary. Thus the individual has no incentive to control utilization.

At times business has taken a rather simplistic viewpoint of rising health care costs and arrived at the conclusion that all that is needed for health care costs to be controlled is to run the health care industry on a more business-like basis with adequate controls over hospitals and doctors. Although such a plan might superficially appear to be feasible, anyone who has knowledge of the health care field realizes that providing quality health care is vastly different from manufacturing widgets.

It was in this setting of rising health care costs that the American Medical Association established a program of corporate visitations in 1978 with top AMA leaders visiting nearly 100 of the Fortune 500 companies. The response by business to these AMA visitations has been quite gratifying thus far. These business leaders have become aware that they cannot establish effective health care programs without close involvement by the medical profession.

Among the major factors to be considered by

business is the necessity of employees participating in the financing of health care by the use of deductibles and co-insurance with catastrophic coverage available. Programs to improve the lifestyle of the participants in health care plans need to be developed. Proper diet and adequate exercise with control of smoking and the proper use of alcohol and drugs would make major inroads into the need for health care.

By supporting programs of education in the proper use of the automobile, business could help to reduce the carnage on our streets and highways. A reduction in automobile accidents would play a major role in reducing the cost of health care.

Business should become aware of the impact on health care costs being made by the skyrocketing costs of professional liability insurance. The medical profession needs the support of business in bringing reason into the field of professional liability.

It also should be noted that labor is becoming aware of the need to do something about the increasing cost of health care. Labor is finding out that the increasing cost of health care is beginning to have a negative impact on the actual income received by the individual worker since there are only a limited number of dollars available.

The need to control health care cost is not solely the responsibility of business and labor. Physicians have a major role to play in this matter. Physicians are the only ones who can control utilization of health care facilities

and diagnostic procedures and still make certain that proper quality of care is maintained. No one else can make this determination.

It is important for physicians to become properly informed as to the costs of the various therapeutic and diagnostic procedures to which their patients are subjected. In the past physicians have had little concern about the cost of health care because all of their efforts were directed to the care of the patient without regard to cost. Unfortunately, there is no longer a blank check for health care and physicians must become involved in preventing unnecessary utilization of facilities and procedures.

As the AMA program has developed, coalitions of medicine and business have been formed around the country. These coalitions are largely in their infancy but already positive results are beginning to be felt. Coalitions of this type are now being formed in several locations in Florida. It is absolutely essential for physicians to be involved as full members of the top policy-making bodies in these coalitions so that they can make certain that quality of medical care is not compromised in the rush to save dollars.

Quality and economy are not necessarily mutually exclusive if the proper individuals are controlling the situation. All county medical societies in Florida are urged to look into this matter and become involved in medicine-business coalitions whenever appropriate.

Sanford A. Pullen, M.D.

UNIVERSITY OF MIAMI
SCHOOL OF MEDICINE

TUTORIAL COURSES OF
INSTRUCTION IN
CORONARY CARE

Director: Louis Lemberg, M.D.

Co-Directors: Kyriacos Pefkaros, M.D.
Robert J. Myerburg, M.D.

SCHEDULE OF COURSES

1981

August 3-8
September 14-19
October 26-31
December 7-12

1982

January 18-23
February 15-20
March 8-13
March 29-April 3
June 14-19

(For more information please call (305) 325-6411 or complete coupon and mail to: M. Enriquez, Division of Cardiology (D-39), University of Miami School of Medicine, Post Office Box 016960, Miami, Florida 33101).

Please send me more information regarding
Tutorial Courses of Instruction in Coronary Care

Name _____

Phone () _____

Address _____

_____ Zip _____



**How the sale/leaseback
can beat the cost of the
average bank loan.**

Find out from your free computerized analysis comparing the after-tax cost of sale/leaseback with a bank loan.

This information is custom-tailored to your individual financial profile. You'll learn how to convert your office equipment into immediate cash — up to \$100,000. Since leaseback payments are tax-deductible, many health professionals in your tax bracket prefer this confidential transaction to a bank loan. To put our computer to work for you, write or phone for complete information on this and our other financial plans.



(305) 831-1625

**Leasing Services of
Florida, Inc.
Post Office Box 146
Altamonte Springs,
Florida 32701**

MICROSURGERY COURSES

The Microsurgery Laboratory at the University of Florida offers three and five day courses aimed at teaching techniques applicable to:

Extracranial to Intracranial Bypass
Digital Reimplantation
Tubal Reanastomosis
Vasovasostomy
Transsphenoidal Surgery
Temporal Bone Dissection
Other Microsurgical Operations

For Information write:

Mrs. Cindy Brady
Microsurgery Laboratory
Box J265
University of Florida Health Center
Gainesville, FL 32610

When we help establish your practice, your primary cares will be solved.

To establish a Primary Care practice, your first need is to solve your primary cares. That's where we come in.

We can offer you a choice of over 60 well equipped acute care hospitals coast to coast. We can offer you selected financial assistance. We can offer you management consulting.

So whether you're interested in a solo, partnership, or group practice, contact NME today.

We'll help establish your practice. And solve your primary cares.

For further information, contact:
Raymond C. Prulitt, Director, Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.
Call Toll-Free 800-421-7470
or collect (213) 479-5526.

**NATIONAL MEDICAL
ENTERPRISES, INC.**



"The Total Health Care Company."

An Equal Opportunity Employer M/F

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid over-sedation. Terminate dosage gradually since abrupt withdrawal of any anti-anxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chloridiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levaterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

**Ativan[®] (lorazepam)
for Anxiety**

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; Insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.



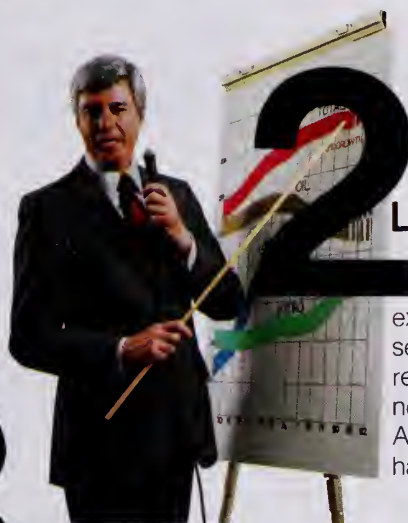
Four practical reasons to prescribe **Ativan[®]** for (lorazepam) **Anxiety***



1

No interaction with more than 300 drugs[†]

In clinical studies, Ativan was given concomitantly with hundreds of medications, including gastrointestinal and cardiovascular, with no reported interactions. Whereas the interaction of diazepam and cimetidine has been shown to cause increased sedation in patients taking both drugs, the clearance of Ativan is not delayed by Tagamet.[‡]







2

Lets most patients stay active

Long-acting benzodiazepines have long-acting metabolites with activity which can produce excessive accumulation that may lead to unwanted sedation. Ativan[®] has no active metabolites, reaches steady state in 2 to 3 days and usually does not cause oversedation. Also, the shorter half-life of Ativan is consistent with b.i.d. dosage, so drug hangover is seldom a problem the next morning.

3

Not appreciably affected by aging

Unlike the long-acting benzodiazepines—diazepam , chlordiazepoxide , clorazepate  and prazepam —the metabolism and clearance of Ativan are not appreciably affected by the aging process.



4

Not significantly affected by liver dysfunction

Ativan[®] is metabolized in one simple step to an inactive glucuronide; its absorption and excretion are not significantly altered by cirrhosis or hepatitis. By contrast, the metabolism of diazepam and chlordiazepoxide has been reported to be significantly altered in patients with liver dysfunction.

* Anxiety or tension associated with the stress of every day life usually does not require treatment with an anxiolytic.

† All benzodiazepines, however, produce additive effects when given with CNS depressants, such as barbiturates or alcohol.

‡ Tagamet (cimetidine) is a registered trademark of Smith Kline & French Laboratories, Division of SmithKline Corporation.

Copyright © 1981, Wyeth Laboratories. All rights reserved.

See important information on following page.

Wyeth Laboratories
Philadelphia, PA 19101



TM

**REINSURANCE
BROKERS for
Florida Physicians
Insurance Reciprocal
—serving physicians
throughout Florida**



**The
Wetzel
Company,
Inc.**

P.O. Box 66452 • Houston, Texas 77006



Professional Liability Legal Update

No-Code Orders

One of today's most pressing medico-legal issues concerns the right of terminally ill patients to refuse the administration of extraordinary remedies that might temporarily prolong their lives. In particular, many practicing physicians have expressed concern over their rights and obligations with respect to the initiation of cardio pulmonary resuscitation (CPR) on patients that are suffering from an underlying incurable medical condition.

CPR is unique among therapeutic modalities in that it is initiated without a physician's order when cardiac or respiratory arrest is recognized. A specific instruction is necessary if CPR is not to be initiated. The term "No-Code Order" or do not resuscitate (DNR) order refers to the suspension of the otherwise automatic initiation of CPR. The question is, when and under what circumstances can a physician enter a No-Code Order.

The most pertinent legal decision in Florida involved a case in which 73-year-old Abe Perlmutter, suffering from incurable amyotrophic lateral sclerosis, sought judicial permission to remove a mechanical respirator that was temporarily keeping him alive. Although Mr. Perlmutter's decision was made with the full approval of his family, the State's Attorney objected contending, among other things, that termination of treatment would amount to suicide. The court rejected the State's contention expressing the view that there was a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the situation where "the issue is not whether, but when, or how long, and at what cost to the individual his life may be briefly extended". Thus, the court concluded that Mr. Perlmutter, a competent but terminally ill adult, should be allowed the right to refuse or discontinue treatment and die with dignity. In doing so, the court expressly limited its holdings to the facts presented to it. Nonetheless,

I believe that the legal principles announced in that decision would permit a physician to enter a No-Code Order for a competent, but terminally ill adult, when death is inevitable and both the patient and his family do not desire extraordinary measures to be utilized to temporarily prolong his life.

The question of the right of incompetent patients to refuse such treatment has not been dealt with by Florida Courts, and as yet remains undetermined. However, there are judicial decisions from other jurisdictions, supported by compelling social and economic interests, that I feel should grant the same right to incompetents under appropriate circumstances.

Even among decisions dealing with terminally ill incompetents, there appears to be a uniform recognition that incompetent patients also have a constitutionally protected right to privacy that allows them to refuse medical treatment under appropriate circumstances. It is the circumstances under which the right to refuse treatment may be exercised that differs. One line of reasoning represented by the *Karen Quinlan* case, holds that an incompetent patient has the right to refuse medical treatment and that the right can be exercised through a "substituted decision making" process. In this case, the New Jersey Supreme Court suggested that such decisions could be made without the necessity of court involvement if the attending physician, the guardian and the family were in agreement that life support functions could appropriately be terminated, and if the case were reviewed by a hospital committee to further certify the propriety of eliminating the treatment. The court further suggests that under these circumstances, no legal sanctions would be imposed on those that participated in that decision making process or in the effectuation of the decision to terminate life support.

An opposing view was presented by the Massachusetts Supreme Court in *Superintendent of Belchertown State School v. Sarkewicz*, when it explicitly rejected the suggestion in *Quinlan* that such decision could be resolved by a hospital review committee without judicial intervention. The Court insisted that it was the duty and

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

function of the court to decide these issues and concluded that in the future all such decisions would be decided by the courts.

The requirement for prior court approval in such cases, with its incumbent expense and delay, seems not only to place an enormous financial and emotional burden on the family of the dying patient but also in many cases seems totally impractical. Possibly in recognition of these problems, recent decisions seem to be moving away from the requirement for prior court approval in all cases. For instance, *In re Dinnerstein*, decided by a Massachusetts Appellate Court approximately 1 year after the decision in *Saikewicz*, involved a patient suffering from a degenerative disease of the brain which typically leads to a vegetative condition and death. An action was brought by the attending physician with the concurrence of the patient's children, seeking a determination of their right to have a No-Code Order entered. The court held that prior court approval was not needed before a physician could write a "No-Code Order" on a "hopeless" patient. It is noteworthy that the court in *Dinnerstein* did not mention any guardian having been appointed for the patient. This may suggest that the court felt that the physician could utilize a No-Code Order with respect to an incompetent patient without the express appointment and consent of a guardian.

Likewise, a recent New York Appellate court held that a mentally incompetent moribund should have the same right as others to dispense with treatment that merely prolongs suffering. Therefore, the court ruled that a close relative (in this case the mother) or a medical committee could substitute their judgment for that of the incompetent patient in deciding to refuse further medical treatment.

Thus, although the question has not been judicially resolved in Florida, it seems that the right to issue No-Code Orders for incompetent, terminally ill patients should, likewise, be recognized in appropriate circumstances, without the need of prior court approval.

It is my opinion that the judiciary should have a very limited and sharply defined role to play in cases involving the medical care of incompetent patients. First, where there are no next of kin, the courts must appoint a guard-

ian. Secondly, when there are differences of opinion, among the family or between physician and family, as to what should be done, the court should be consulted. And finally, when there is any complaint of injury or wrong doing or malpractice, that is a matter for judicial resolution. But where there is unanimity of opinion between family and physician, where the physician's recommendations have been made under circumstances that assure soundness of judgment and conformity with the professional standard, and where there is no complaint of wrong doing, I see no reason for involvement of the judiciary.

One word of caution, however. I think physicians must recognize the possibilities for abuse that exist when decisions are made privately between the patient's family and the attending physician. There is no denying the possibility, however remote, that one or more of the parties to the decision may not always be acting with the purest motives, or with the patient's interest foremost in mind. I have argued that routine prior judicial intervention is an inappropriate and unworkable solution. I also believe that closed, totally private decisions, unreviewed by any third party, are a cause of legitimate concern. A more reasonable alternative, it seems to me, is to establish some relatively simple and informal, but nonetheless meaningful, consultative process within the profession. When physicians make life or death decisions for incompetent patients, (assuming, always, consent of the family or legal guardian), concurrence by several colleagues who have no vested interest in the decision should be documented in the medical record.

Finally, any decision to enter a No-Code Order should be made with an awareness of the statutory definition of "brain death". Section 382.085, Florida Statutes provides, in effect, that the occurrence of death may be determined where there is "the irreversible cessation of the functioning of the entire brain, including the brain stem", determined in accordance with currently accepted reasonable medical standards by two physicians licensed under Chapter 458 or 459. One physician shall be the treating physician and the other shall be a board-eligible or board-certified neurologist, neurosurgeon, internist, pediatrician, surgeon or anesthesiologist. In addition, proper notice must be given to the next of kin and documented in the medical records.

How do you get 10 lbs. of sugar ...in a 5 lb. bag?

IT'S EASIER THAN YOU THINK
WHEN YOU HAVE 'TECHNIQUE'.

AS A MICROGRAPHICS SERVICE COMPANY WE...

- have the ability to film at your location or in our lab
- provide next day turn around with free pick-up and delivery when filming in our lab
- have the ability to legally destroy original documents
- have the ability to batch film to keep you up-to-date (by the month, by the quarter, by the year)
- provide a cost and use analysis to help our clients determine the best service for their particular needs (microfiche for active files and microfilm for inactive files)
- provide 'security' for those important files

For more answers to storage and retrieval problems, call or write today.



MICROTECHNIQUE, INC.
8022 Office Court, Suite 202
Orlando, FL (305) 851-0189

When
impotence
is due to androgenic deficiency.

Android® 5^{Buccal} / 10^{Oral} / 25^{Oral}
Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-pubertal cryptorchidism.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity: end gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. E. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

Write for new double blind study reprints and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



EIGHTH ANNUAL REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE

**"FUNDAMENTAL AND CLINICAL
ASPECTS OF INTERNAL MEDICINE"**

**SHERATON
BAL HARBOUR**

August 9 - 22, 1981

**MIAMI BEACH
FLORIDA**

Director: Maxwell McKenzie, M.D.
Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for *certification in internal medicine*. It will provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Twelve printed texts, references and self-assessment questionnaires will be provided to all registrants. Pictorial quizzes, patient management problems, videotape symposia and audiovisual teaching aids will be offered throughout the meeting. Upon request the twelve textbooks and self-assessment questionnaires will be forwarded to each registrant before the course begins. This course will end 23 days prior to the certification examination of the American Board of Internal Medicine, thereby providing time for assimilation.

Week I (August 9-15)

Cardiology
Pulmonary
Electrolytes — Renal
Hypertension — Critical Care
Neurology — Psychiatry — Radiology
Ophthalmology — Pharmacology — Toxicology
Dermatology — Laboratory — Geriatrics

Week II (August 16-22)

Endocrinology — Pathology
Infectious Disease — Immunology — Allergy
Rheumatology
Gastroenterology — Hepatology
Hematology
Genetics — Oncology — Nuclear Medicine

HIGHLIGHTS . . .

- | | |
|--|---|
| • Audio-Visual Aids | • Set of 12 Textbooks |
| • Pictorial Quiz | • Self-Assessment Questionnaires |
| • Self-Assessment Sessions | • Meet the Faculty Sessions |
| • Patient Management Problems | • Video Tape Symposia |
| • 88 Lecture Hours of Credit, Category I | • 65 Self-Instruction Hours of Credit, Category I |

Registration: \$650* Entire Course (August 9-22, 1981)
\$400 Week I (August 9-15)
\$400 Week II (August 16-22)

Enrollment must be limited because of extensive faculty/management interaction.

For registration and information write to:

Jose S. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760, Miami, Florida 33101
Phone: (305) 547-6063

*Includes tuition, set of textbooks, self-assessment questionnaires, use of audiovisual aids, library loan of T.V. tapes, cassette tapes and set of slides.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

JULY 1981
VOL 68 • NO. 7

Emergency Management of Scuba Diving Accidents

Barbara B. Tabeling, M.D., and T. James Gallagher, M.D.

Abstract: Scuba-diving accidents can cause serious neurologic injury which is frequently reversed by hyperbaric oxygen therapy. It is critical that the physician evaluating the diver understands the types of injuries that may occur and implement emergency measures for stabilization and transfer of the patient to a hyperbaric facility.

Scuba diving is an increasingly popular sport and many divers enjoy Florida's springs, underwater caves, ocean and gulf. As a result, diving accidents are increasing in number and frequency. Many accidents involve novice divers with inadequate training for the dive undertaken, however experienced divers are often injured as well. While many accidents result in immediate death, physicians in any part of the state may be suddenly confronted with a critically-ill diver requiring immediate therapy.

The types of serious injuries which a diver may incur fall into three categories: drowning and near-drowning, decompression sickness (bends) and pulmonary over-pressure accident with cerebral air embolism. Of these, the latter two require emergency recompression in a hyperbaric chamber. A near-drowned scuba diver may pose particular difficulty in diagnosis if he is not alert and cooperative at the time of evaluation. It must be assumed that he has suffered cerebral air embolism or decompression sickness in addition to near-drowning.

The Authors

BARBARA B. TABELING, M.D.

Dr. Tabeling is Assistant Professor of Anesthesiology and Surgery at the University of Florida and Medical Director of Respiratory Care Services at Shands Teaching Hospital and Clinics, Inc.

T. JAMES GALLAGHER, M.D.

Dr. Gallagher is Associate Professor of Anesthesiology and Surgery and Chief of the Division of Critical Care Medicine of the Department of Anesthesiology at the University of Florida. He is also Medical Director of the Surgical Intensive Care Unit and the Jerome Johns Hyperbaric Chamber at Shands Teaching Hospital and Clinics, Inc.

Decompression Sickness

Decompression sickness (Type I DCS) may present as joint pain without neurologic deficits ("bends"), fatigue, skin rash or lymphedema of an extremity. While only those divers with joint pain require hyperbaric oxygen therapy for Type I DCS, when the other manifestations occur soon after diving, more serious injury may follow. Type I DCS usually occurs within two hours after diving but it may be delayed for as long as 24 hours. The degree of pain is variable and more than one joint may be involved. Since the pain may be severe and since aseptic necrosis of the joint may develop years after DCS, hyperbaric oxygen therapy is indicated even when initial eval-

uation is delayed.

Decompression sickness (DCS) is due to the release of dissolved nitrogen from the tissues at a rate which allows nitrogen bubbles to form in the tissues and the vascular compartment. The amount of nitrogen dissolved in the body while breathing compressed air depends on the depth and duration of the dive and on individual factors such as body build. If the diver does not perform adequate decompression while ascending from depth, the nitrogen may be released from the tissues too rapidly. This can happen even when the diver follows appropriate decompression tables, but frequently the diver miscalculates the depth or duration of the dive or may make an emergency ascent without decompression stops. All manifestations of DCS are serious and must be treated accordingly.

Type II decompression sickness includes more serious manifestations which require immediate recompression and include neurologic DCS, labyrinthine DCS, the "chokes" and DCS shock. Neurologic DCS occurs in 15-20% of cases and usually involves the spinal cord. It can be distinguished from air embolism in that the onset of symptoms of DCS occurs gradually after diving. Frequently the victim complains of back pain or numbness in the toes which progresses to paraplegia or quadriplegia within hours. Other victims may present with upper extremity numbness or weakness or loss of proprioception. Frequently the abnormal findings do not fit a specific anatomical pattern. The mechanism of neurologic DCS is not well understood, but it is believed that nitrogen bubbles interact with platelets to cause the release of vasoactive substances and cause stasis of the venous drainage of the spinal cord.

Other manifestations of Type II DCS are rare. Laby-

rinthine DCS is believed to be due to nitrogen bubbles in the perilymph of the semicircular canals. Symptoms include nystagmus, vertigo, severe nausea and tinnitus. Recompression within one hour is crucial for satisfactory resolution. The "chokes" is manifested by substernal chest pain, dyspnea and coughing and is believed to be due to nitrogen bubble formation in the pulmonary circulation which causes the release of vasoactive substances and an increase in pulmonary vascular resistance. Decompression sickness shock is the most severe form of DCS and results in profound hypotension or cardiac arrest. Severe hypovolemia and disseminated intravascular coagulation are usually present. Immediate recompression in a hyperbaric chamber is necessary even when cardiopulmonary resuscitation is on-going.

All patients with Type II DCS must be assumed to be hypovolemic. Aggressive intravenous fluid therapy is mandatory and urinary output should be monitored closely. Serial hematocrit determinations are helpful for monitoring the severity of hypovolemia, but invasive hemodynamic monitoring may be necessary in some cases. Aspirin should be given whenever possible to decrease platelet adhesiveness. All patients should be given the highest possible concentration of inspired oxygen during evaluation and transportation to a hyperbaric facility.

Cerebral Air Embolism

Pulmonary overpressure accident with cerebral air embolism may occur while breathing compressed air at any depth greater than 3-5 feet. Cases have occurred in swimming pools. Precipitating factors include laryngospasm, panic or buddy-breathing. It may occur following an apparently normal ascent by a diver with unsuspected air-trapping due to pulmonary disease, such as a mucus plug or pulmonary bleb. The onset of symptoms is immediate and the diver may be unconscious or may suffer a seizure upon surfacing. Other common presentations include focal paralysis, hemiplegia, blindness and headache. Again, the findings may not fit neatly into an anatomical pattern. As the diver ascends, the gas within the body expands and exhalation is necessary to reduce the volume of gas. If the gas is not exhaled, the pressure within the air-containing space may exceed that of the surrounding water by 50-100 torr and the air-containing space may rupture. When this occurs, air enters the pulmonary circulation by unknown mechanisms and may result in air embolism to the brain, heart and other organs. In addition, pneumothorax, pneumomediastinum or subcutaneous emphysema may occur with or without cerebral air embolism.

While pulmonary overpressure accidents resulting in subcutaneous emphysema without neurologic abnormality are treated conservatively, any evidence of cere-

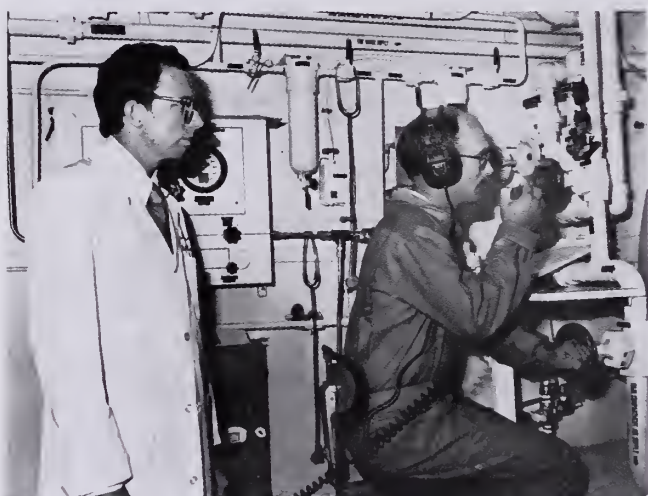


Fig. 1. — The chamber operator has continuous communication with the inside personnel. While the physician usually supervises the treatment from the operation room, occasionally it becomes necessary for the physician to attend the patient inside the chamber.

bral air embolism requires emergency recompression in addition to appropriate management of any barotrauma present. Aggressive intravenous fluid therapy is necessary because severe hemoconcentration occurs. Intravenous corticosteroids may be given for cerebral edema. The highest possible concentration of inspired oxygen should be provided during evaluation and transport to the hyperbaric facility. The patient should be kept in the Trendelenberg position to facilitate blood flow to the involved cerebral vessel.

Drowning and Near-drowning

Drowning and near-drowning may occur with or without the aspiration of water. The majority of victims aspirate water and present with varying degrees of hypoxemia due to absolute intrapulmonary shunting of blood. After freshwater aspiration, this is due to damage to pulmonary surfactant resulting in alveolar collapse. After seawater aspiration, shunting is due to the perfusion of fluid-filled alveoli. Even when water is not aspirated, the near-drowned victim may suffer sufficient cerebral hypoxia before rescue that severe brain damage may result. Regardless of the type of water aspirated, continuous positive airway pressure (CPAP) or positive end-expiratory pressure (PEEP) is the treatment of choice for the hypoxemia of near-drowning. Intermittent mandatory ventilation (IMV) is instituted when respiratory acidosis occurs. Since most near-drowned victims become hypovolemic due to pulmonary edema and third-space sequestration of fluid, aggressive intravenous fluid therapy with a balanced salt solution is indicated. Treatment is often facilitated by the use of intra-arterial and pulmonary artery catheters for analysis of blood gas tensions and for cardiac output and intrapulmonary shunt determinations.

Evaluation and Initial Management of the Diving Victim

Any diver with the potential diagnosis of decompression sickness or cerebral air embolism should undergo immediate evaluation and referral to a hyperbaric facility. Initial evaluation includes a rapid but thorough neurologic examination and evaluation of the cardiovascular and pulmonary systems. When time permits, a chest roentgenogram should be obtained and sent with the patient. If near-drowning is suspected, arterial blood gas analysis should be performed and appropriate therapy instituted while awaiting transfer. A large-bore intravenous catheter should be inserted in all victims with Type II DCS or cerebral air embolism and aggressive fluid therapy instituted. An electrocardiogram should be obtained and a urinary catheter inserted if these pro-

Problems: "Bends"
Decompression sickness
Air embolism

For information or referral call: (904) 392-2834 (24 hour line) (Ask for hyperbaric physician on call).

Facility: Jerome Johns Hyperbaric Facility
Shands Teaching Hospital and Clinics, Inc.
Archer Road
Gainesville, Florida 32610

Access: (Ground) I-75 to Archer Road, then east on Archer Road.
(Air) 1. V.A. helipad across the street from Shands.
2. Gainesville Municipal Airport (6 miles from Shands)

For stabilization and transfer of all diving accident victims:

1. Notify hyperbaric facility
2. Arrange transportation immediately
3. Provide airway protection if unconscious
4. Provide high concentration of oxygen
5. Start intravenous fluid therapy
6. Give aspirin when possible
7. Maintain patient in Trendelenberg position
8. Transport with skilled personnel in attendance
9. Transport diving partner when possible

Information required:

1. Name of victim
2. Brief history of dive
3. Current condition of patient
4. Initial therapy instituted
5. Estimated time of arrival

cedures do not delay transfer. The patient should be maintained in the Trendelenberg position and an endotracheal tube inserted for airway protection if the patient is unconscious. A high concentration of inspired oxygen should be given to all patients. Aspirin and/or corticosteroid therapy may be instituted prior to transfer. The possibility of deterioration requires that the victim receive intense monitoring by skilled personnel at all times.

Transfer to a Hyperbaric Facility

As soon as the diagnosis of DCS or air embolism is suspected, immediate referral to a hyperbaric facility is mandatory. The hyperbaric facility should be contacted promptly and arrangements made for the most rapid and

safe transportation possible. By notifying the hyperbaric facility immediately, appropriate arrangements can be made to facilitate recompression therapy immediately upon arrival. Transportation to the hyperbaric facility may include air transportation in a pressurized plane (preferably to sea level) or low-flying helicopter when the distance is great or the patient's condition requires it. Care must be taken to avoid decreased atmospheric pressure, since this will increase the release of nitrogen from tissues which may worsen the patient's condition. When ground transportation is necessary or desirable, the patient must be transported in an adequately equipped ambulance with skilled personnel, including a physician whenever possible. All supportive measures instituted during initial therapy are continued. When possible, the victim's diving partner should accompany him to the hyperbaric facility to provide further information about the patient and the diving profile.

Jerome Johns Hyperbaric Facility at the University of Florida

The Jerome Johns Hyperbaric Facility at Shands Teaching Hospital at the University of Florida provides 24-hour emergency information and treatment for victims of scuba diving accidents. A physician is available for consultation at all times by calling (904) 392-2834. The physician will assist with initial assessment, provide recommendations for therapy during transportation and alert the emergency room and hyperbaric facility staff of the emergency.

Ambulance transportation from the Veteran's

Administration helipad or the Gainesville Municipal Airport will be arranged and a physician will meet the patient upon landing whenever possible. When the victim is transported by ambulance, the physician will meet the patient in the emergency room.

The hyperbaric treatment team consists of medical staff from the Critical Care Medicine Division of the Department of Anesthesiology. At least three chamber technicians, consisting of respiratory therapists, nurses, paramedics or emergency medical technicians, complete the treatment team. The treatment is supervised by a physician, while the chamber operation is supervised by the chamber supervisor. The operator controls the depth and timing of the treatment, while at least one inside attendant cares for the patient while in the chamber. Critically-ill patients may require two or more inside attendants, including a physician.

The hyperbaric chamber is a multiplace chamber constructed for NASA. It can accommodate four persons comfortably in the main chamber at any time. Additional personnel can enter or leave the main chamber through a transfer lock. All equipment and staff necessary to provide intensive care within the chamber, including mechanical ventilation, electrocardiographic monitoring, invasive hemodynamic monitoring and cardiac defibrillation are available. Medical supplies and drugs are sent into the chamber through a small medical lock.

Recompression therapy consists of achieving an appropriate pressure for the diagnosis, usually the equivalent of 165 feet of seawater for cerebral air embolism

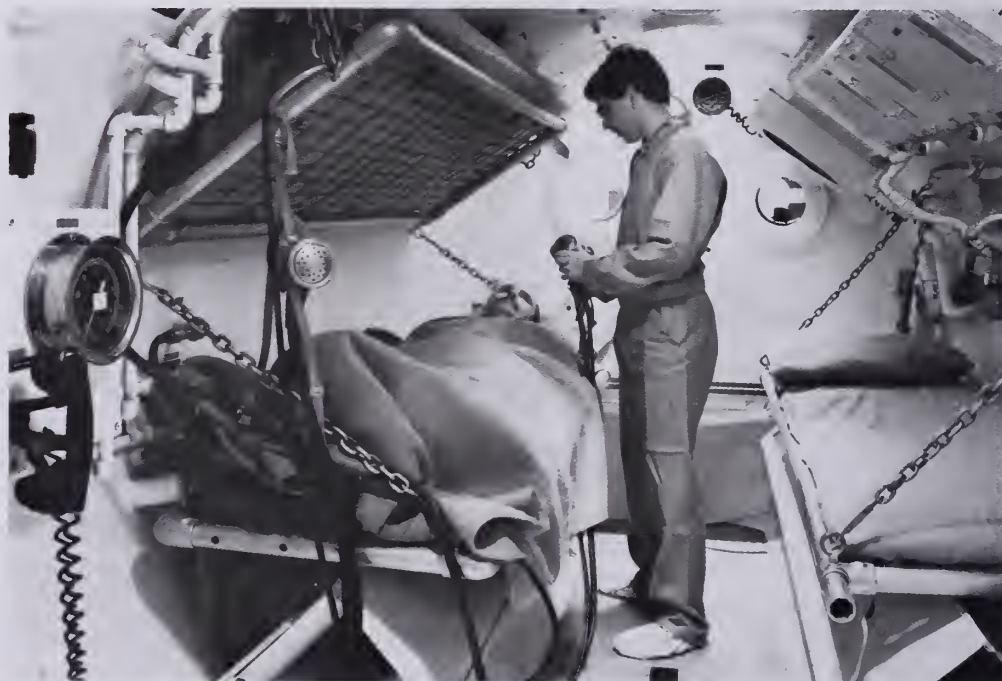


Fig. 2.—The main chamber can accommodate three patients on bunks. Here the attendant explains the oxygen mask the patient will wear during his therapy.

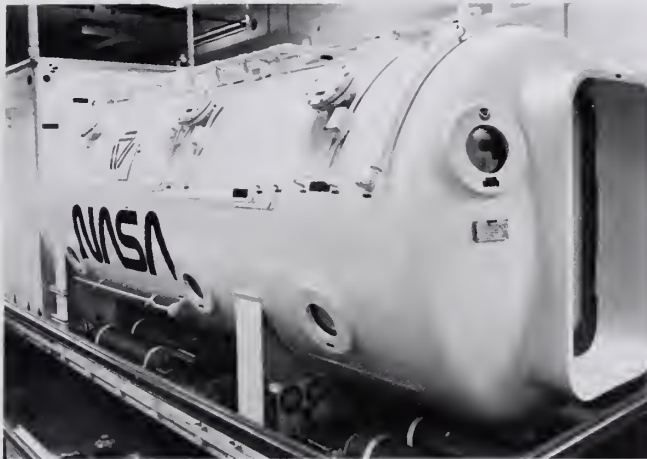


Fig. 3. — The hyperbaric chamber is a self-contained multiplace chamber constructed for NASA. It consists of a main chamber, a personnel transfer chamber and a chamber operation room.

and 60 feet of seawater for DCS. The patient is given oxygen to breathe to remove the nitrogen from the body and is decompressed slowly while observation and supportive care continues.

Following initial therapy, the stable patient is observed in the emergency room or on the ward. Critically-ill patients are monitored in the intensive care unit. Occa-

sionally repetitive hyperbaric oxygen treatments are indicated.

The hyperbaric facility is available for the emergency treatment of carbon monoxide poisoning and gas gangrene as well as for diving accident victims. The facility is also used on a daily basis for treatment of osteomyelitis, radiation necrosis and other conditions for which hyperbaric oxygen has been demonstrated to be beneficial.

Acknowledgement

The authors would like to thank Patty Barber for photographic assistance.

References

- 1 Davis, J. C.; Hunt, T. K., (eds): Hyperbaric Oxygen Therapy. Bethesda, Undersea Medical Society, 1977.
 - 2 NOAA (National Oceanic and Atmospheric Administration): The NOAA Diving Manual. Washington, U.S. Department of Commerce, 1975.
 - 3 Modell, J. H.; Boysen, P. G.: Respiratory Crises, in Shoemaker, W. C.; Thompson, W. L., (eds): Critical Care: State of the Art, Vol. 1. Fullerton, California, Society of Critical Care Medicine, 1980, pp. 1 (F): 1-38.
- Dr. Tabling, Department of Anesthesiology, Box J-254, JHMHC, University of Florida, Gainesville 32610.

Primitive Hypoglossal Artery Associated with Middle Cerebral Artery Aneurysm

A Case Report

Gaston J. Acosta-Rua, M.D., and William F. McCormick, M.D.

Abstract: A case of primitive hypoglossal artery in association with a middle cerebral artery aneurysm is reported. The criteria for the diagnosis of this anomaly is discussed as well as a brief review of similar reports.

The demonstration of a persistence of a primitive carotid-basilar arterial communication is a relatively uncommon finding at angiography. The described forms of persistent carotid-basilar anastomoses are the trigeminal, otic, proatlantal and the hypoglossal. Only a relatively few cases have been reported where the later has been associated with an intracranial saccular aneurysm. The present report is of a patient with persistence of a primitive right hypoglossal artery in association with a ruptured left middle cerebral artery aneurysm.

A Case Report

A 59-year-old woman was admitted to St. Vincent's Medical Center on October 31, 1976, with a history of sudden onset of generalized weakness and nausea followed by a syncopal episode which lasted about 15 minutes. Upon awakening, she complained of severe occipital headache.

On examination, she was lethargic but easily aroused. Blood pressure was 160/110. The neck was stiff. The rest of the general physical and the neurological examination was normal. Lumbar puncture showed grossly bloody cerebrospinal fluid with an opening pressure of 330mm H₂O.

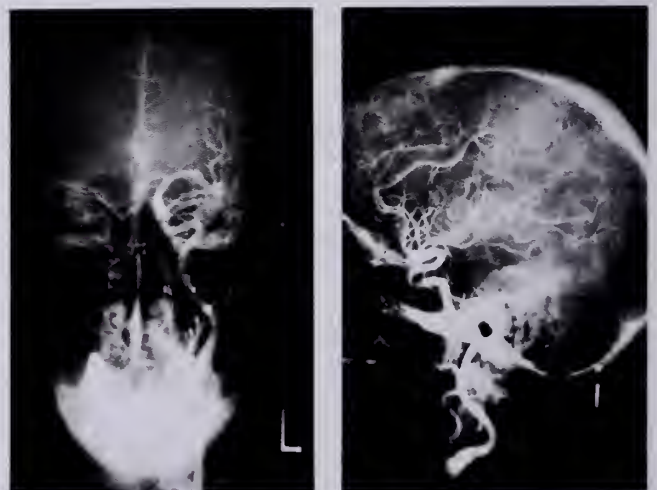
Complete angiography via femoral approach revealed absence of the right vertebral artery, a hypoplastic left vertebral artery, an aneurysm at the bifurcation of the left middle cerebral artery (Fig. 1 and 2), and a primitive hypoglossal artery on the right arising at C2 level (Figs. 3 and 4).

On November 7, 1976, a left frontotemporal craniotomy was performed and the neck of the aneurysm was clipped. The patient did well, was discharged home with no neurological deficit and has remained neurologically intact.

Discussion

Batujeff¹ did the original report and Lie² described all the persistent carotid-basilar and carotid-vertebral anastomoses. He proposed that four conditions must be fulfilled for the diagnosis of the primitive hypoglossal artery:

1. The artery must arise as a robust branch from the internal carotid artery at the level of C1-3;
2. The artery enters the posterior cranial fossa through the anterior condyloid foramen (the hypoglossal canal);
3. The basilar artery is filled only beyond the point of junction with the anastomosis;



Figs. 1. & 2. — Left carotid angiography shows a left middle cerebral artery aneurysm.

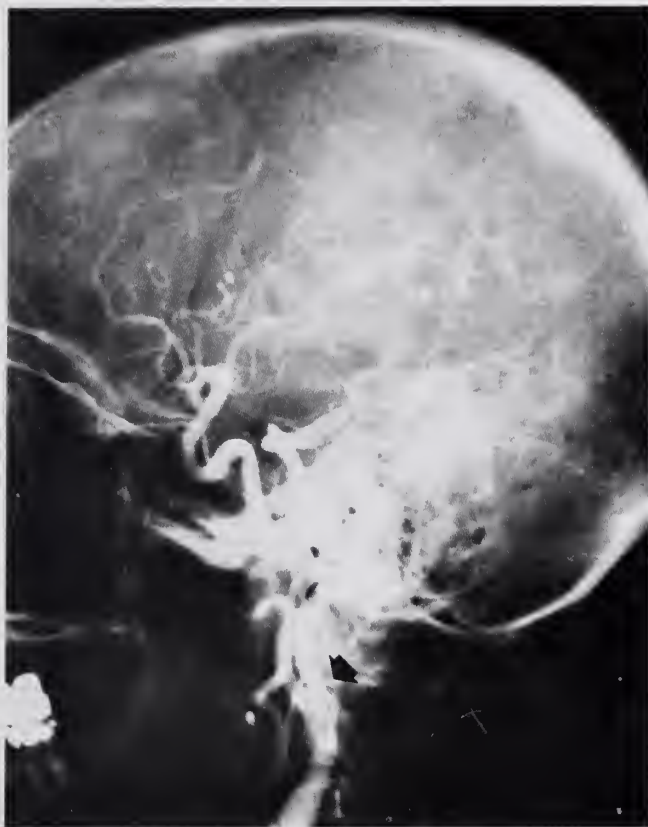
The Authors

GASTON J. ACOSTA-RUA, M.D.

Dr. Acosta-Rua is Chief, Department of Neurosurgery, St. Vincent's Medical Center, Jacksonville.

WILLIAM F. MCCORMICK, M.D.

Dr. McCormick is Chief, Division of Neuropathology, University of Texas Medical Branch, Galveston, Texas.



Figs. 3. & 4. — Right carotid angiogram shows the primitive hypoglossal artery.



Table 1. — Persistent Hypoglossal Artery Associated with Intracranial Aneurysm

Authors	Age & Sex of Patient	Site of Aneurysm
1. Udvarhelyi & Lai (3)	26 Male	Left hypoglossal artery
2. Lie (2)	41 Female	Right internal carotid artery
3. Lecuire, et al (4)	41 Female	Right internal carotid bifurcation ("first portion of anterior cerebral")
4. Lapras, et al (5)	Not Stated	Internal carotid artery bifurcation
5. Drake (6)	52 Female	Right hypoglossal artery
6. Bohmfalk & Story (7)	44 Female	Left hypoglossal artery, right middle cerebral artery and right internal carotid ophthalmic junction
7. Suzuki (8)	34 Female	Hypoglossal artery
8. Suzuki (8)	48 Female	Anterior communicating artery
9. Huber & Revoir (9)	62 Female	Left hypoglossal artery
10. Springer, et al (10)	60 Male	Right superior cerebellar artery
11. Matsushita (11)	40 Female	Left anterior cerebral and hypoglossal artery
12. Kodama, T., et al (12)	44 Male	Basilar artery bifurcation
13. Fujioka & Nawata (13)	58 Female	Right posterior cerebral artery
14. Kodama, N., et al (14)	48 Female	Left anterior communicating artery
15. Kodama, N., et al (14)	34 Female	Right hypoglossal artery
16. Bongartz, et al (15)	28 Female	Left hypoglossal artery
17. Morimoto, et al (16)	51 Male	Right anterior cerebral artery
18. Acosta-Rua & McCormick	59 Female	Left middle cerebral artery

4. The posterior communicating artery is absent or hypoplastic.

The present case completely satisfied these criteria. Previous case reports suggest that this anomaly is an incidental finding during arteriography and of no clinical significance per se. We know of seventeen previous reports of this arterial anomaly in association with saccular aneurysms (Table 1). This case appears to be the second in which the aneurysm was located on the middle cerebral artery. About half of the saccular aneurysms in patients with persistent hypoglossal arteries have been on the anterior circulation, which is less than expected from the aneurysm population as a whole.

References

1. Batueff, N.: Eineseltene Arterienanomalie (Ursprung der A. basilaris aus der A. carotis interna). *Anat. Anz.*, 4:282-285, 1889.
2. Lie, T.A.: Congenital Anomalies of the Carotid Arteries. Amsterdam Excerpta Medica, 76-84, 1968.
3. Udvarhelyi, G.B., Lai, M.: Subarachnoid Hemorrhage Due to Rupture of an Aneurysm on a Persistent Left Hypoglossal Artery. *Brit. J. Radiol.*, 36:843-847, 1963.
4. Lecuire, J.; Buffard, P.; Goutelle, A.; Dechaume, J.P.; Michel, D.; Rambaud, G.; Verger, D.: Considerations Anatomiques, Cliniques et Radiologiques a Propos d'une Artere

- Hypglosse, J. *Radiol. Electrol.*,
5. Lapras, Cl.; Thierry, A.; Michel, D.; Dechaume, J.P.; Mansuy, L.: Signes Radiologiques des Aneurysmes Intracranien du Systeme Carotidien. *Neurochirurgia (Stuttgart)*, 8:172-187, 1965.
6. Drake, C.G.: Further Experience with Surgical Treatment of Aneurysms of the Basilar Artery. *J. Neurosurgery*, Vol. 29, Oct. 1968.
7. Bohmfalk, G.L. and Story, J.L.: Aneurysms of the Persistent Hypoglossal Artery. *Neurosurgery*, 1:291-296, 1977.
8. Okubo, T.; Ohara, H.; Sato, S.; Kodama, N.; Suzuki, J.: Persistent Primitive Hypoglossal Artery with Intracranial Aneurysm. Two Cases of Successful Direct Aneurysm Surgery. *Proceedings of the 1st Surgical Treatment of Stroke. (Senai, Japan)* 99-107, 1972.
9. Huber, P. and Rivoir, R.: Aneurysm on a Persistent Left Hypoglossal Artery. *Neuroradiology*, 6:277-278 (1974) by Springer-Verlag, 1974.
10. Springer, T.D.; Fishbone, G.; Shapiro, R.: Persistent Hypoglossal Artery Associated with Superior Cerebellar Artery Aneurysm. *Case Report. J. Neurosurgery*, 40:397-399, 1974.
11. Matsushita, N.; Kawase, T.; Hirai, H.; Saito, Y.: Primitive Hypoglossal Artery as a Cause of Subarachnoid Hemorrhage. The 16th Annual Meeting of the Japanese Society of Neurology. Osaka, Japan, 1975.
12. Kodama, T.; Masumitsu, T. and Matsukado, T.: Primitive Hypoglossal Artery Associated with Basilar Artery Aneurysm. *Surg. Neurol.*, 6:279-281, 1976.
13. Fujioka, M. and Nawata, H.: Arteria Primitiva Hypoglossica Revealed by Associated Cerebrovascular Accident: Report of Two Cases. *Brain Nerve (Tokyo)*, 25:1235-1242, 1973.
14. Kodama, N.; Ohara, H. and Suzuki, J.: Persistent Hypoglossal Artery Associated with Aneurysm. *Journal of Neurosurgery*, 45:449-451, 1976.
15. Bongartz, E.B.; Nau, H.E. and Grote, W.: Successful Operative Treatment of an Aneurysm on a Left Persistent Hypoglossal Artery. *Neurochirurgia*, 20:169-173, 1977.
16. Morimoto, M.; Aoki, H. and Eguchi, S.: Persistent Primitive Hypoglossal Artery with Intracranial Aneurysm. No. To. Shinkei, 29:621-626, 1977.

- Dr. Acosta-Rua, 2545 Riverside Avenue, Jacksonville 32204.

Impaired Physician Monograph Available from FMA

The Florida Medical Association has acquired a number of copies of a monograph entitled "The Impaired Physician: An Overview."

Blue Cross and Blue Shield of Florida obtained the copies and donated them to FMA as a service. The monograph was prepared by John-Henry Pfifferling, Ph.D., of the Center for the Well-Being of Health Professionals in Chapel Hill, N.C., and was published by the Health Sciences Consortium of Chapel Hill.

A post test is provided and physicians who complete it and send the answer sheet to the Consortium with a small fee will be awarded two hours of AMA Category I continuing medical education credit.

FMA members may obtain copies free of charge by contacting Mr. Edward D. Hagan, Director of Scientific Activities, Florida Medical Association, P.O. Box 2411, Jacksonville, Florida 32203, telephone (904) 356-1571.

Diagnosis of Intradural Sacral Lipoma and Tethered Cord by Computed Tomography

F. Reed Murtagh, M.D., and Gene A. Balis, M.D.

Abstract: A case is presented of a young man with recurrent intradural spinal lipoma associated with tethered cord. The fatty nature of the tumor was identified by the use of computed tomographic technology.

Intradural sacral lipoma with tethered cord is rare and occurs primarily in young people. It has been well described.¹⁻⁸ Myelographic findings usually are highly suggestive of these intraspinal fatty neoplasms but the advent of computed tomography has made possible pre-operative tissue diagnosis.

Report of Case

A 32-year-old white man was admitted to the Veterans Administration Hospital in Tampa, Florida, with minimal symptoms which included decreasing sphincter tone and numbness in his feet of six months duration. What was described as a sacral spinal lipoma had been removed surgically 12 years previously with no neurological sequelae.

A metrizamide lumbar myelogram revealed an intradural filling defect in the caudal sac located dorsally and to the left (Fig. 1). Several nerve roots of the cauda equina were detected matted together extending from this level cephalad representing involvement of the nerve roots with the lipoma in a tethered cord arrangement.

Identification of the intradural mass as a lipoma was suggested by computed tomographic (CT) scan with metrizamide in the subarachnoid space (Fig. 2). The lesion measured -225 delta absorption units, consistent with fat. Plain films had shown a smooth large dorsal defect of the sacrum, too smooth and regular to have been altogether due to the previous surgery. A history of pilonidal sinus in this area had been given by the patient before the first operation.

He refused surgery and will be followed closely.

The Authors

F. REED MURTAGH, M.D., GENE A. BALIS, M.D.

Dr. Murtagh and Dr. Balis are from the Neuroradiology Division, Department of Radiology, and Neurosurgery Division, Department of Surgery, University of South Florida College of Medicine, Tampa, and the Tampa Veterans Administration Hospital

Discussion

Intraspinal lipomas constitute only about 1% of all

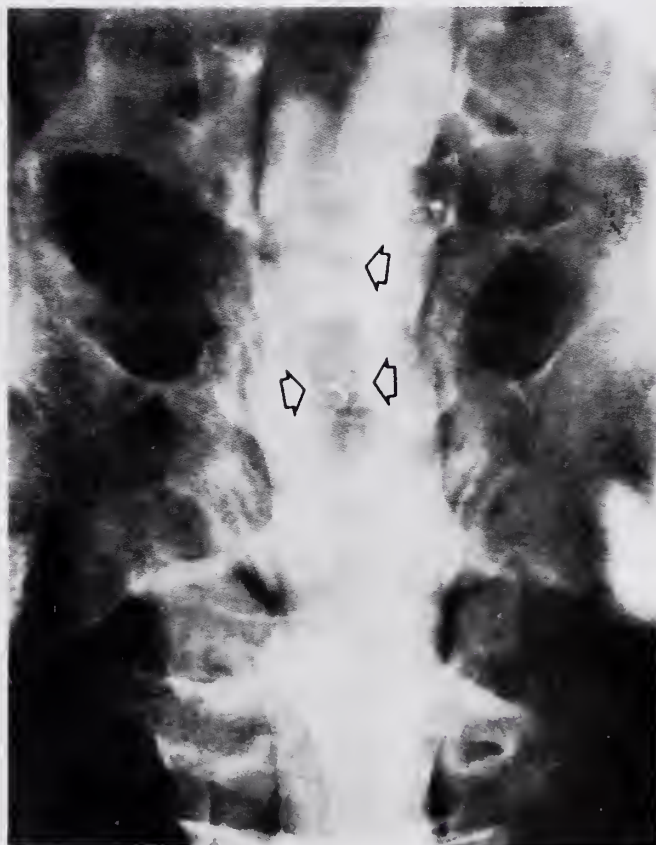


Fig. 1.—A metrizamide lumbar myelogram revealed an intradural filling defect in the caudal sac located dorsally and to the left.

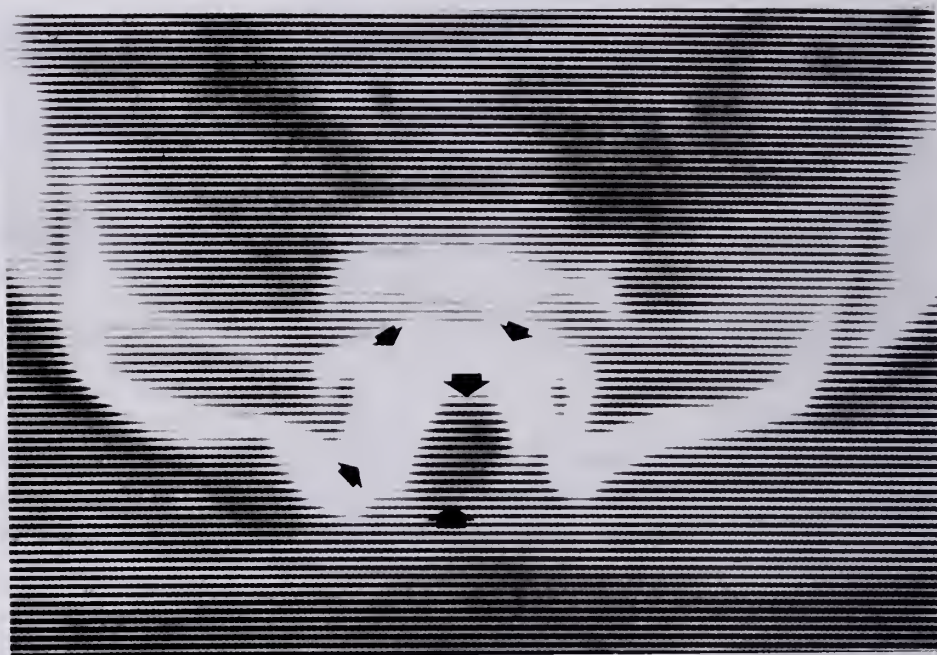


Fig. 2.—Identification of the intradural mass as a lipoma was suggested by computed tomographic (CT) scan with metrizamide in the subarachnoid space.

intraspinous tumors with less than $\frac{1}{4}$ occurring in the lumbosacral region.⁵ Lipomas in this region are associated most frequently with bony canal congenital defects. Associated with spina bifida, they occur primarily in children under five years of age, but are rare.^{1,3}

Concurrence of tethered cord with intraspinal lipoma has been emphasized. Patient symptomatology has been attributed to the mechanical effect of tethering upon the neural structures rather than to direct involvement of the lipoma destroying or infiltrating sacral nerve roots.

Computed tomography was particularly useful in our patient because of its ability to identify tissue by x-ray absorption coefficient, accurately and reproducibly in the case of fat and fatty tumors. Identification of fatty tissue in lipomas of the mediastinum and chest wall is well documented^{9,10-12} but to our knowledge has not been reported with lesions within the spinal canal. We believe that with CT we should be able to identify the recurrent lipoma within the sacral canal.

References

1. Lassman, L.P. and James, C.C.M.: Lumbosacral Lipomas, *J. Neurol., NS Psych.* 30:174, 1967.
2. Loeser, J.D. and Lewin, R.J.: Lumbosacral Lipoma in Adult, *J. Neurol.* 29:405, 1968.
3. Rogers, H.M., et al: Lipomas of Spinal Cord and Cauda Equina, *J. Neuros.* 34:349, 1971.
4. Thomas, J.E. and Miller, R.H.: Lipomas of Spinal Canal, Study of Their Clinical Range, *Mayo Clin. Proc.* 49:393, 1973.
5. Epstein, B.S.: *The Spine: Radiographic Text and Atlas*, 4th ed., Lea and Febiger, Philadelphia, 1976, p. 343.
6. Bothra, M.L.: Intradural Lipoma, *J. Indian M. A.* 66:(6)128-130, 1976.
7. Kumar, S.: Intradural Spinal Lipoma, *Neurol. India* 24:(4)188-190, 1976.
8. Kishi, M.: Epidural Lipoma Simulating Ruptured Disc, *Surg. Neurol.* 9:(2)133-135, 1978.
9. Faer, M.J.; Burnam, R.E. and Beck, E.L.: Transmural Thoracic Lipoma, Demonstration by CT, *AJR* 130:161-163, 1978.
10. Rohlfing, B.M.; Korobkin, M. and Hall, A.D.: CT of Intrathoracic Omental Herniation and Mediastinal Fatty Masses, *J. Comput. Assist. Tomog.* 1:181-183, 1977.
11. Roub, L.W. and Drayer, B.P.: Spinal Computed Tomography, Limitations and Applications, *AJR* 133:267-273, 1979.
12. Mendez, G.; Isikoff, M.B.; Isikoff, S.K. and Simner, W.N.: Fatty Tumors of Thorax Demonstrated by CT, *AJR* 133:207-212, 1979.

- Dr. Murtagh, Department of Radiology, 12901 North 30th Street, Box 17, Tampa 33612.

A Community-Based Colon and Rectal Cancer Screening Program

Joseph K. Isley Jr., M.D., and Richard B. Akin

Abstract: The key to increasing the cure rate of cancer of the colon and rectum is early detection. A simple test which lends itself well to applications of large groups of people, is inexpensive and readily available, is the Guaiac Paper Slide Test. This test was used in a community based program with very gratifying and significant results.

Malignancy of the colon and rectum is the second largest cause of death from cancer in the United States. In 1980, it is estimated there will be 114,000 new cases and 53,000 deaths from this disease. The death rate from this cancer has changed very little since 1930 in spite of improvement in surgical, radiation, and chemotherapeutic techniques.

A key to improving the survival most likely lies in the early detection of malignant disease. The best overall approach to this early detection in the general population is through the use of a screening procedure. As melena is a common finding in neoplasm of the colon, and always demands further investigation, it was felt that a test for the detection of blood in the stool might be used.

In order to be effective, a screening procedure must be inexpensive, simple to carry out, and easy to interpret. It must not be unpleasant or offensive to the patient, and must be readily available to those people who request it.

We selected the Guaiac Paper Test for blood as our procedure.

The Authors

JOSEPH K. ISLEY JR., M.D.

Dr. Isley is in the private practice of radiology in Fort Myers, and is a long-time cancer volunteer.

RICHARD B. AKIN

Mr. Akin is Assistant Director of Collier Health Services, Inc., Collier County, Florida. At the time of this study he was Environmentalist of the Lee County Health Department.

The purpose of this work was two-fold: First to study the mechanism of a communitywide effort encompassing two organizations, one being the Lee County Health Department in Lee County, Florida, and the other being the Lee County Unit of the American Cancer Society. The second was to study the effectiveness of detecting neoplasm and other gastrointestinal disease in a program designed for practical and inexpensive application, and adaptable to a large segment of the population.

Materials and Methods

A Guaiac Paper Slide Test (Hemoccult)* for occult blood was used in this study. This was chosen because of its relatively high sensitivity, low false positivity, and convenience of specimen collection and analysis.

Publicity for this program was contributed primarily by one of our local television stations.** A series of five-minute programs given at prime time daily for one week prior to initiation of this study, and having to do with cancer in general, was carried out along with the reminder of the upcoming Guaiac Paper Slide Study. A brochure pertaining to the television program series, and to the study was distributed concurrently.

Two weeks were allowed for the dispersement of the slides and a second two weeks for the collection and return of the specimens. Slides were given out at the Lee

*Hemoccult Paper Slide Test for fecal occult blood. Smith-Kline Diagnostics

**WBBH Television — Channel 20 — Fort Myers, Florida

Table 1. — Guaiac Paper Slide Test — Return and Results

	Number	Percent
Total number of tests given out	1,484	
Total number of tests returned	1,257	84.7
Total number of tests positive on first study	207	16.5
Total number of tests positive after diagnostic diet	53	4.2

County Unit of the American Cancer Society and the Lee County Health Department. All completed slides were returned to the health department where they were processed. Prior to dispensing the test kit, the applicant was asked to complete a questionnaire which inquired about medical history, reason for participation, and sociological and biographical background. Instructions were provided regarding specimen collection, specimen return, and other pertinent information.

Initially, specimens were collected without diet preparation. If this first study was negative, no further action was taken. However, if this study was positive, the patient was placed on a special diagnostic diet for three days and the test repeated. Those positive on the repeat study were referred to their private physician, who was notified of the results.

Each positive study was followed by us until the examining physician had made a determination as to the meaning of the positive study. Those studies which were negative, either on the initial test or after the diagnostic diet, were not followed. For these negative studies, individual report sheets were sent to the participant's physician.

Results

A total of 1,484 test kits were dispensed, of which 1,257 (84.7%) were returned. Initially, there were 207 (16.5%) positives. After placing these 207 participants on the diagnostic diet, the number of positives was reduced to 53 (4.2%).

Participation was greatest among the 60-70 year old age group. This group also accounted for more than half

Table 3. — Sex and Race vs. Results

	Positive	Percent	Negative	Percent
Male	27	50.9	546	45.3
Female	26	49.1	658	54.6
Black	1	1.9	12	1.0
White	52	98.1	1,190	98.8
Other	0	—	2	0.2

of the total positive tests. There were slightly more females than males, but both males and females had approximately the same number of positives. Almost the entire study was composed of caucasians (98%).

The accompanying tables reflect data collected concerning these and various other parameters which we attempted to measure through the questionnaire.

Discussion

We feel that the participation rate (rate of return) was relatively high (84.7%), and warrants further comment. Very possibly, the requirement that the participant complete a questionnaire with name and address is one factor in such a high yield. Since we knew their identity, the participant may have felt more obligated to complete the test and return it.

Another factor in the high rate was the fact that many of the participants believed that they currently had some sign or symptom of colorectal cancer. This could be the most significant observation of the study. Table 2 shows that 455 people who participated in the study had either a change in bowel habits or rectal bleeding. This represents 36.2% of the total return, and would suggest that a substantial percentage participated in hopes of identifying an actively present problem. This group was probably not concerned about discovering an unsuspected disease process.

Also worth noting is that 49 of the 53 positive studies had either a recent change in bowel habits or rectal bleeding. Why, then, did these people choose the study in lieu of seeing their private physician?

Approximately equal percentages of positive and negative studies described a family history of colon or rectal cancer (see Table 2). But the positive group was almost twice as likely to have had a history of some digestive disease.

Table 2. — Medical History vs. Results

	Positive	Percent	Negative	Percent
Family history of colon or rectal cancer	8	15.1	200	16.6
History of digestive disease	19	35.8	227	18.9
History of recent change in bowel habits	21	39.6	232	19.3
History of recent rectal bleeding	18	34.0	184	15.3

Table 4. — Age vs. Results

	Positive	Percent	Negative	Percent
20 Years	0		18	1.5
20-30 Years	0		32	2.7
30-40 Years	2	3.8	65	5.4
40-50 Years	4	7.5	86	7.1
50-60 Years	7	13.2	322	26.7
60-70 Years	28	52.8	475	39.5
70 Years	12	22.6	206	17.1

One other observation is interesting about participation. Younger people (less than 40 years) did show an interest in the study. They accounted for 9.2% of the total volume. They also represented a significant portion (45%) of those who listed "precautionary measure" as the reason for participation.

Our positivity rate closely paralleled rates published by Smith Kline Diagnostics as appropriate for the "Hemoccult." The final yield was 4.2% positive, as compared to an expected 3%-5%.

Smith Kline Diagnostics advocated the diagnostic diet preparation prior to the initial test. We did not feel that this was feasible for our study, and did not advise participants of the diet at the outset. As a result, our positivity rate was initially 16.5%. Since no data is available concerning yield without the preparatory diet, we are really uncertain as to the acceptability of our result. However, 16.5% seems to be tolerable, especially in view of the advantage achieved by allowing participation without any preparation.

Table 6 analyzes the false positives. After the study had been under way for only a few days, it appeared that

older people were accounting for more than a proportional share of the false positives. As age increased, the frequency of false positives also increased. In the 30-40 age group, the frequency of participation doubled the frequency of false positives. Then, as the age increased, false positivity rate increased. For example, the 60-70 year age group only accounted for 38.5% of the total participation, yet they accounted for 44.2% of the total false positives.

Table 7 reflects the final determination of the 53 positives. Twenty-three serious or potentially serious conditions were identified. Four of these positives were cancer of the colon or rectum. Based upon age distribution and incidence of colorectal cancer in the general populus, these four cases represent about sixteen times the expected yield for such a study. This high yield can probably be accounted for by heavy participation among the older age groups and those who had signs or symptoms.

One of these four cases was asymptomatic. Discovery of this asymptomatic case alone was most rewarding.

Table 7 also indicates that the paper guaiac test is most useful in aiding the identification of various other GI conditions.

In any screening program, the simple mechanics of distribution, collections, processing, and data-gathering create the need for considerable coordination. From the outset, we tried to anticipate problems, but unexpected obstacles arose. Some of these problems tested our ingenuity, while other difficulties had to be tolerated. Hopefully, future program design will consider some of these recently recognized problems and attempt to alleviate them.

We felt that others might benefit from some of our conclusions, along with suggestions as to workable solutions. Listed below are suggestions which may assist in the formulation of a successful screening program:

Table 5. — Education vs. Results

Number of Years Education	Positive	Percent	Negative	Percent
<12	12	22.6	297	24.7
12	21	39.6	460	38.2
13-14	6	11.3	173	14.4
15-16	10	18.9	146	12.1
>16	2	3.8	100	8.3
No Reply or Unknown	2	3.8	28	2.3

Table 6. — Age vs. False Positives

Age	Number	Percent of Total	Percent of Total Participation
<20	1	0.6	1.5
20-30	3	1.9	2.5
30-40	4	2.6	5.7
40-50	8	5.2	7.4
50-60	36	23.4	26.9
60-70	68	44.2	38.5
>70	34	22.1	17.6
	154		

Table 7. — Probable Etiology of Positive Tests

	Number	Percent
Colorectal cancer	4	7.5
Polyps	8	15.1
Ulcer	1	1.9
Hiatal hernia	2	3.8
Diverticulosis	9	17.0
Other	3	5.7
No disease found	25	47.2
Did not contact physician	1	1.9
	53	

1. Slides should be given only to people appearing in person, or at least actively pursuing them,
2. A questionnaire should be completed prior to dispensing the test kit.
3. Questions should be asked in the most specific fashion

possible, with a forced choice answer when appropriate.

4. Those persons dispensing the test kit should be knowledgeable about the procedure, and, if possible, provide the participant with printed material directed at key questions.
5. A number system may be helpful.
6. Sufficient publicity, carried out in advance, is most helpful.
7. Contingencies should be made for those participants who lack a physician.
8. Support of the local medical societies is very helpful.
9. Where feasible, publicity should be directed at high-yield groups.

We would like to express our appreciation to Dr. Joseph W. Lawrence and Mrs. Bessie Fowler of the Lee County Health Department; Ms. Helen La Forge and Jean Lopez of the American Cancer Society; and Mr. Howard Hoffman and Mr. Al Reuchel of WBBH-TV Channel 20, for their most able assistance in this project, and to the Florida Division of the American Cancer Society for donation of the "Hemocult" slides.

- Mr. Akin, Rt. 1, Box 491 Q, Ft. Myers 33905.

Colin Blakemore is Guest Lecturer at UF

Colin Blakemore, author of *Mechanics of the Mind*, will present two lectures at the University of Florida beginning at 2 p.m., Friday, July 24th.

Dr. Blakemore, Professor and Chairman of Physiology at Oxford University, will talk on "Interaction of Genes and Environment in the Development of the Brain", and "Development of the Neural Mechanism

of Visual Acuity in the Monkey". The session will be held in Room C 1-3 of the Communicore Building, J. Hillis Miller Health Center.


Further information is available from the Division of Continuing Medical Education, Department of Medicine, University of Florida, (904) 392-3143.



Acute pain is no laughing matter.

The first prescription for the first days of acute pain

Empirin® \bar{c} Codeine #3


Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg. (Warning — may be habit-forming). 

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin \bar{c} Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin \bar{c} Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin \bar{c} Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming). 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

THE HOT SUN, A COOL BREEZE AND FLORIDA SEAFOOD

Summertime's Finest

What finer combination? Right now is the time to order Florida's Finest Seafood, fresh from the Atlantic and Gulf, to you or your friends.

This seafood is Flash Frozen to ensure freshness, and ready for immediate heating and serving. We've done the preparation, all you have to do is thaw, and heat, and then sit back and listen to the raves.

Lobster Thermidor, Florida Lobster, Stone Crab Claws, Shore Dinners, Pompano Papillote, Swordfish Steaks — all of these delicious treats await you and your guests for the asking.

And, for the first time, our **Rare Jumbo Shrimp**. These spectacular Jumbo's are peeled and deveined, ready for cooking and eating. These beauties are over 4 inches long, and the taste is mouth-watering! (3# — \$59.75; 6# — \$89.75). This is **pure shrimp, no shells** — **100% edible** — ready to boil, steam or fry.

REMEMBER — these Florida Delicacies are available all year long — but, summertime is seafood time.

Healthful, Delicious and Low Calorie! The Perfect Combination! Surprise your family and friends with **FLORIDA'S FINEST SEAFOOD**.

Use this handy order form below, or contact your local Chairman or President, or write:

Mrs. David Whittaker
Florida Medical Association Auxiliary
1140 S.E. Fort King Street
Ocala, Florida 32670
(904) 622-6605

Benefits go to the Florida Medical Association. Make checks payable to "FMA-Auxiliary — FMF".

All orders arrive in our own styrofoam container, which can be used again and again. All products are unconditionally guaranteed.

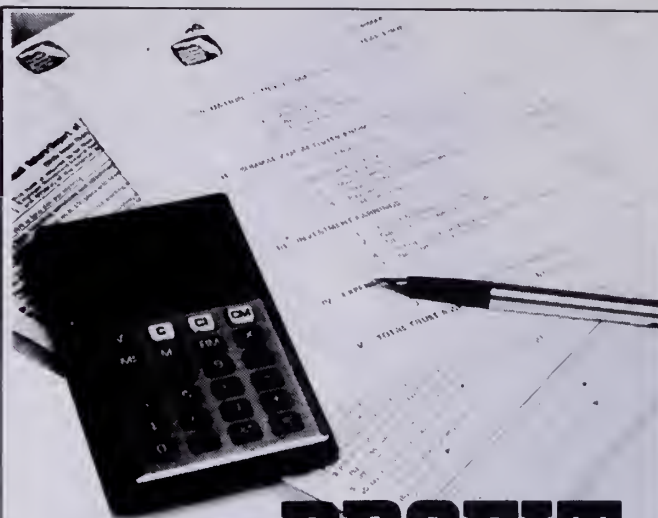
Name: _____

Address: _____

Phone No.: _____

Item Ordered: _____ Cost: _____

Brochure Requested: ☐



PROFIT FROM OUR EXPERIENCE

For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

We specialize in attaining the results that you require from your account in the areas of:

- **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.
- **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.
- **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

PEOPLE WHO KNOW HOW.

**Florida National
Trust Services**

214 Hogan Street
Jacksonville, Florida 32231
Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC

K⁺ **chLORide** uni **wax** **maTRIX**

SLOW-RELEASE TABLETS 10 mEq



KLOTRIX[®]
**(POTASSIUM
CHLORIDE)**

MeadJohnson
PHARMACEUTICAL DIVISION

**When you need
a lot of money,
DAC and your
house may be
the best friends
you have.**



As a physician, cash flow and large dollar requirements can sometimes be a problem. Probably one of your biggest assets and surest means of obtaining large cash sums is your home equity.

Let DAC show you how simple it can be to arrange a home equity loan. Loans are available for up to \$50,000 or more with terms up to 12 years.

So, if you need cash for setting up or expanding a practice, new equipment, business investments, major purchases, etc., call your nearest DAC office — there are 13 in Florida!

Licensed Mortgage Broker

DAC
Corp. of Fla.

An affiliate of The Old Stone Bank

Professionals Helping Professionals For Over 20 Years

Bradenton
6221 14th St. West
756-9575

Clearwater
2280 U.S. Highway 19 N.
796-2587

Daytona Beach
2040 S. Ridgewood Ave.
761-8500

Ft. Lauderdale
1771 N. W. 40th Ave.
735-5111

Jacksonville
3986 Boulevard Center Dr.
396-9496

Lakeland
402 S. Kentucky Ave.
687-2533

Melbourne
17 E. Hibiscus Blvd.
727-3510

Ocala
2945 N. E. 3rd St.
732-4336

Orlando
3438 Lawton Rd.
894-3711

Pensacola
5150 Bayou Blvd.
478-3215

Tallahassee
2574 Seagate Dr.
878-3149

Tampa
402 Reo St.
879-3181

West Palm Beach 2240 Palm Beach Lakes Rd. 689-0080

Familial Ovarian Cancer Registry



There are increasing reports of ovarian cancer occurring in two (2) or more family members. The Familial Ovarian Cancer Registry will evaluate this increase to obtain information for genetic counseling to family members. Case accrual will evaluate:

- the number of cases of familial ovarian cancer
- the type of inheritance
- the relationship to breast and endometrial carcinoma
- the study of environmental, geographical and racial factors
- genetic counseling.

Please address inquiries regarding the clinical history of any family with two (2) or more members with ovarian cancer to:

Familial Ovarian Cancer Registry
M. Steven Piver, MD • Roswell Park Memorial Institute
New York State Department of Health • 666 Elm Street
Buffalo, New York 14263
Telephone: (716) 845-3110



Two convenient dosage forms: 100 mg (white) and 300 mg (peach) Scored Tablets



Tablets imprinted with brand name to assist in tablet identification.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Florida Medical Association House of Delegates Proceedings

One Hundred Seventh Annual Meeting
Florida Medical Association, Inc.
Hollywood, April 29 - May 3, 1981

President's Address
T. Byron Thames, M.D.

T. Byron Thames, M.D., outgoing President of the Florida Medical Association addressed the House of Delegates during the opening session on Wednesday, April 29.



Outgoing President T. Byron Thames, M.D., Orlando, reports to the House of Delegates on FMA activities during his term of office.

Dr. Thames opened his address to the House of Delegates by introducing various people who, he said, had enabled him to carry out the duties of being the Association's president this past year. First, Dr. Thames introduced his wife, Pat, Past President of the Auxiliary to the FMA and, first and foremost, a constant companion and tireless worker on his behalf and on behalf of the Association. Next to be introduced was Madeline Lange, Dr. Thames' nurse for over 18 years; and last, Dr. Thames introduced his office manager, organizer, and right-hand assistant, Marie Waller. Dr. Thames also expressed public thanks to his seven partners and his entire office staff who he said had carried on so ably in his frequent absences.

In reviewing the Association's activities over the past year, Dr. Thames recalled some of the most important events of the Association, going back to May 1980 when the Legislature passed the Recovery of Costs Bill for Medical Professional Liability cases, much of the credit for which justly went to Richard S. Hodes, M.D., the FMA staff, FMA lobbyists and especially FMA Auxiliary. Recent reports from the Florida Physicians' Insurance Reciprocal showed a decrease in the number of malpractice cases filed since this law took effect which, Dr. Thames' said, was the good news. However, Dr. Thames added that the bad news was the severity of claims which had markedly increased and showed that the malpractice problem was not yet being held in check. It was expected that the Association would continue to publicize the contingency fee aspect of the problem to educate the public to the unfair costs which were imposed on them.

Next, Dr. Thames reminded everyone of the establishment of the Impaired Physicians Program as directed by the House of Delegates in 1980. The Impaired Physicians Program committee, chaired by Dr. Guy Selander,

has hired a Medical Director, established a hot line, begun to train intervenors and has been funded by the Board of Governors for \$75,000 through 1981. The Auxiliary has continued to help in every way with this fine project dedicated to helping our own colleagues.

Dr. Thames referred next to a special finance committee, chaired by Dr. Russell Forlaw and composed of Doctors Forlaw, Windom and Thames which was established to set up a special trust fund to provide future financial security to the FMA. The fund is presently being administered by Doctors MaCris, Murray and Davenport. In addition, Dr. Thames said, it has reviewed the general finances of the organization and made its recommendations concerning the dues necessary to carry out the Association's functions. The committee will continue to report to the House through the Board of Governors with recommendations on financial matters annually.

Also established was a special committee on FMA management composed of Chairman, Dr. Vernon Astler, Dr. Perry and Dr. Thames and, in the future, also to include the incumbent president of the FMA, to provide for an orderly transition of authority in the future after the retirement of the Association's present Executive Vice President, Dr. Parham, which is currently planned for after the annual meeting in 1984. Dr. Thames said the committee had established a line of authority through Mr. Don Jones, Executive Director, and Mr. John Thrasher, Associate Executive Director and Legal Counsel, who supervises all legal activities and public relations programs including legislation. The committee will continue to monitor the activities of FMA staff and decide if outside personnel need to be recruited to continue the outstanding staff support.

Dr. Thames said that after the 1980 House met, the councils of the FMA were restructured and some deleted, leaving us with the Council on Legislation, Council on Health Care Financing, Council on Medical Services, Council on Scientific Activities, Council on Specialty Medicine and the Judicial Council. This streamlining resulted in cost savings without jeopardizing needed services. Dr. Thames pointed to the fact that each of these Councils had functioned efficiently.

Throughout the year, the Association has continued an active Public Relations program, including visits by officers and local county society officers to each of the leading newspapers in Tampa, St. Petersburg, Miami, Ft. Lauderdale, Palm Beach, Orlando, Jacksonville and Tallahassee; meeting with their editorial boards to discuss mutual medical problems of interest. A new emergency medical film was produced and shown on prime-time TV, thanks being given to Dr. Vernon Astler, who continues to serve as the PR officer to the Board of Governors. There were multiple talks on radio and tele-

vision which were given by many county and state officers and especially by Dr. Ed Annis.

In January of 1981, more than 200 officers and others from county medical societies, representing 96% of the FMA membership attended the Leadership Conference at Lake Buena Vista for an update on FMA activities. Governor Bob Graham was the keynote luncheon speaker at the Leadership Conference, but all the participants contributed greatly to the success of this program. Dr. Thames pointed to the fact that the Association had continued to try to improve communications between members and others. A new FMA field office in Orlando has been set up, separate from the Tampa office which has been considered especially necessary because of the last census. County medical society officers have been invited to attend the Board of Governors meeting and county societies have been informed of important agenda items of the Board 30 days prior to the Board meetings. Also, Dr. Thames said, special meetings have been held with county medical society executives at FMA headquarters shortly after each Board meeting. The Association has also published briefs of each Board meeting in *The FMA Journal* as well as countless other items of interest in a truly outstanding Journal which, Dr. Thames added, was a tribute to all of Florida medicine under the able editorship of Dr. Dan Nunn.

Dr. Thames said that we are presently in the midst of a legislative session with many items of interest to each of us including restrictions on practice by Registered Nurse Practitioners and the curbing of optometrists from treating eye diseases and many more.

Whatever has been accomplished in this past year Dr. Thames said could not have been done without the support of his fellow officers, the Board of Governors, Council and Committee chairmen and members, the House of Delegates and each and every member of the Florida Medical Association. He extended special thanks to the Auxiliary and its President, Ann Swing who, he said, did so much for us all.

Dr. Thames said that for years he had seen Presidents stop to thank the staff for all they did and that he had never completely appreciated how true their expressions of gratitude had been. Now, at this time, Dr. Thames said he recognized how much the organization owed to Dr. Harold Parham and all the staff for a job well done.

Ending his address to the House, Dr. Thames said that as he became Past President of "this great and glorious organization" he would remember those days of 1980 and 1981 when he had been allowed to serve as President and those happy memories, he said, would make him feel perhaps, as Wadsworth did when he wrote "The Daffodils":

Retiring President T. Byron Thames, M.D. (center) acknowledges a standing ovation from the House of Delegates in recognition of the accomplishments of his administration. Joining in are FMA Secretary Robert E. Windom, M.D. (left) and Executive Vice President W. Harold Parham, D.H.A.



*"For oft, when on my couch I lie,
In vacant or in pensive mood,
They flash upon that inward eye
which is the bliss of solitude;
and then my heart with pleasure fills
and dances with the daffodils."*

But, Dr. Thames added, he felt this through the friendship and support he had been given, like those words of Invictus:

*"Out of the night that covers me
Black as the pit from pole to pole
I thank whatever gods may be
For my unconquerable soul.
Under the fell clutch of circumstances
I have not winced nor cried aloud
Under the bludgeonings of chance
My head is bloody but unbowed."*

Dr. Thames thanked each and everyone — "May God bless the Florida Medical Association and each of us."

First House of Delegates

The First House of Delegates convened at 4:30 p.m., on Wednesday, April 29, 1981 in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with James B. Perry, M.D., Speaker of the House, presiding.

The House rose for the Invocation which was given by Luis M. Perez, M.D.

Dr. Perry announced the membership of the Credentials Committee:

Reginald J. Stambaugh, M.D., Chairman
William H. Meyer Jr., M.D.
Harry P. Weinberg, M.D.

The Delegates were reminded that they must register with the Credentials Committee before this and every meeting of the House of Delegates.

Dr. Stambaugh, Chairman of the Credentials Committee, announced that 163 Delegates were present, representing 39 component societies, which constitutes a quorum.

A motion carried to seat Delegates.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; William T. Hawkins, M.D.; Douglas O. Jenkins, M.D.; (Absent — William B. Deal, M.D.; Edward R. Woodward, M.D.; Diane M. Zabak, Student Delegate)

BAY — William G. Bruce, M.D.; (Absent — Philip Cotton, M.D.)

BREVARD — Richard N. Baney, M.D.; Walter J. Carrato, M.D.; Michael J. Foley, M.D.; Brian P. Gibbons, M.D.; Francis S. Pooser, M.D.; Robert J. Sarnowski, M.D.

BROWARD — Joseph A. Benenati, M.D.; Robert J. Brennan, M.D.; Philip A. Caruso, M.D.; Burns A. Dobbins, M.D.; Arthur L. Eberly, M.D.; William C. Hartley, M.D.; Thomas F. Regan, M.D.; William Richman, M.D.; Peter A. Tomasello, M.D.; Harry B. Weinberg, M.D. (Absent — Robert L. Andreae, M.D.; Robert L. Berger, M.D.; Anna M. Blenke, M.D.; David A. d'Alessandro, M.D.; Paul S. Dasher, M.D.; Paul A. Flaten, M.D.; James A. Jordan, M.D.; Robert J. Lenar, M.D.; Stanley S. Goodman, M.D.; Orlando Maytin, M.D.; George P. Messenger, M.D.; Alexander E. Molchan, M.D.; Jerry D. Moore, M.D.; Donald J. Plevy, M.D.; Richard D. Shafron, M.D.; Herbert M. Todd, M.D.; Anthony J. Vento, M.D.; Juan S. Wester, M.D.)

CAPITAL — Merton L. Ekwall, M.D.; Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; Robert N. Webster, M.D.; George N. Lewis, M.D.

CHARLOTTE — Thomas Civitella, M.D.; Joseph R. Goggins, M.D.; Jaime Torner, M.D.

CITRUS-HERNANDO — W. Randall Jenkins, M.D.; Clinton J. McGrew, M.D.

CLAY — Hinson L. Stephens, M.D.

COLLIER — Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.; Allen S. Weiss, M.D.

COLUMBIA — Jose Goyenechea, M.D.

DADE — Joseph Allison, M.D.; Jerome Benson, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; Edmund Cava, M.D.; Manuel L. Carbonell, M.D.; Richard C. Clay, M.D.; Jack Q. Cleveland, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Augusto Fernandez-Conde, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; George R. Gage, M.D.; Julian H. Groff, M.D.; James D. Hanson, M.D.; Joseph Harris, M.D.; Walter C. Jones III, M.D.; Norman M. Kenyon, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Roberto L. Maury, M.D.; Charles A. Monnin, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Arthur Radin, M.D.; William E. Riemer, M.D.; Oscar Sandoval, M.D.; Everett Shocket, M.D.; M. David Sims, M.D.; Margaret C.S. Skinner, M.D.; Douglas Slavin, M.D.; Leonard S. Sommer, M.D.; Chauncey M. Stone, M.D.; Charles F.



President-Elect Sanford A. Mullen, M.D., Jacksonville (far left), addresses a session of the FMA House of Delegates. Others pictured (second from left to right) are: Secretary Robert E. Windom, M.D., Sarasota; President T. Byron Thames, M.D., Orlando; Executive Vice President W. Harold Parham, D.H.A.,

Jacksonville; Speaker of the House James B. Perry, M.D., Fort Lauderdale; Vice Speaker Franklin B. McKechnie, M.D., Winter Park; Vice President Gerold L. Schiebler, M.D., Gainesville; and Treasurer J. Russell Forlaw, M.D., Boynton Beach.

FIRST HOUSE OF DELEGATES

Tate Jr., M.D.; John C. Turner, M.D.; Thomas B. Turner, M.D.; Emilio A. Trujillo, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Steven M. Weissberg, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; Jim Deming, Student Delegate (Absent — Jose S. Bocles, M.D.; Marshall F. Hall, M.D.; Herbert S. Kaiser, M.D.; Miguel Milian, M.D.; Miguel A. Mora, M.D.; Walter W. Sackett, M.D.; S. William Simon, M.D.; S. Peter Stokley, M.D.; Elliot Witkind, M.D.)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Harvey E. Bernhardt, M.D.; William P. Booras, M.D.; Yank D. Coble Jr., M.D.; Patricia C. Cowdery, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Charles P. Hayes Jr., M.D.; Charles W. Lewis Jr., M.D.; Faris S. Monsour Jr., M.D.; Daniel B. Nunn, M.D.; Guy T. Selander, M.D.; James W. Walker, M.D. (Absent — Gaston J. Acosta-Rua, M.D.; James L. Borland, M.D.; Emmet F. Ferguson Jr., M.D.; Walter G. Jarrell, M.D.; John F. Lovejoy Jr., M.D.; Charles B. McIntosh, M.D.)

ESCAMBIA — Paul T. Baroco, M.D.; Rae W. Froelich, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; Theodore J. Marshall, M.D.; C. Fenner McConnell, M.D.

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — Joseph P. Hendrix, M.D.

HIGHLANDS — Robert T. Rengarts, M.D. (Absent — Vinod C. Thakkar, M.D.)

HILLSBOROUGH — Richard A. Bagby, M.D.; Francis C. Coleman, M.D.; Irvin M. Essrig, M.D.; John C. Fletcher, M.D.; Thomas E. McKell, M.D.; John K. Petrakis, M.D.; J. Robert Qualey, M.D.; Ralph E. Rydell, M.D.; Ronald L. Seeley, M.D.; Ralph M. Stephan, M.D.; William W. Trice, M.D.; Harold L. Williamson, M.D.; James A. Winslow Jr., M.D.; Donald Lofland, Student Delegate (Absent — Richard G. Connar, M.D.; Victor H. Knight Jr., M.D.)

INDIAN RIVER — Kip Kelso, M.D.; (Absent — Donald L. Ames, M.D.)

LAKE — Frederick C. Andrews, M.D.; Robert H. Hux, M.D.

LEE — Cecil C. Beehler, M.D.; Larry P. Garrett, M.D.; John S. Hagen, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.

MADISON — no delegate submitted

MANATEE — Thomas R. Busard, M.D.; Michael G. Ryan, M.D. (Absent — Arthur J. Cohen, M.D.; Roger A. Meyer, M.D.)

MARION — C. Brooks Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfro, M.D.

MARTIN — Robert O. Baratta, M.D.; Fred S. Carter, M.D.

MONROE — (Absent — Robert Carraway, M.D.; Ronald H. Chase, M.D.)

NASSAU — (Absent — Jose L. Castillo, M.D.)

OKALOOSA — David R. Arrowsmith, M.D. (Absent — Samuel M. Atkinson Jr., M.D.)

ORANGE — Edward Ackerman, M.D.; Clarence H. Brown III, M.D.; Manuel J. Coto, M.D.; Alberto J. Herran, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; James F. Richards Jr., M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D.; Cecil B. Wilson, M.D. (Absent — Clarence M. Gilbert, M.D.; David L. Mackey, M.D.; James J. Schoeck, M.D.; Robert B. Trumbo, M.D.)

OSCEOLA — Gilberto Perez, M.D.

PALM BEACH — Vernon B. Astler, M.D.; Richard C. Cavanagh, M.D.; John D. Corbitt Jr., M.D.; Jerry F. Cox, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V.A. Marks, M.D.; R. Benjamin Moore, M.D.; Reginald J. Stambaugh, M.D.; Ben R. Thebaut Jr., M.D.; Dick L. Van Eldick, M.D.

PANHANDLE — Herbert E. Brooks, M.D.; K. Sinclair Franz, M.D.

PASCO — David A. Johnson, M.D.; Robert D. May, M.D.

PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Michael H. Diamond, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay Knight Hanley, M.D.; David S. Hubbell, M.D.; Morris J. LeVine, M.D.; Jack A.

MacCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D. (Absent — John F. Lee, M.D.; John M. Thompson, M.D.; Walter H. Winchester, M.D.)

POLK — Thomas M. Caswall, M.D.; John W. Glotfelty, M.D.; Wiley E. Koon, M.D.; Thomas E. McMicken, M.D.; John C. Moore Jr., M.D.; David Stoler, M.D.; Paul A. Tanner Jr., M.D.; (Absent — Stanley W. Lipinski, M.D.)

PUTNAM — Anne Buynitzky, M.D.

ST. LUCIE OKEECHOBEE — Charles R. Cambron, M.D.; William H. Meyer Jr., M.D.

SANTA ROSA — (Absent — Claude J. Barnes, M.D.)

SARASOTA — John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Keihl, M.D.; Martin F. Mihm, M.D.; Franklin H. Pfeifferberger, M.D.; Karl R. Rolls, M.D.; (Absent — Richard C. Rehmyer, M.D.)

SEMINOLE — Luis M. Perez, M.D.; Frederick J. Weigand, M.D.

SUWANNEE HAMILTON-LAFAYETTE — (Absent — Andrew C. Bass, M.D.)

TAYLOR — John H. Parker, M.D.

VOLUSIA — Grandy B. Barnard, M.D.; Charles R. DeArmas, M.D.; William R. Jones, M.D.; Remigio G. Lacsamana, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.

WALTON — (Absent — Howard F. Currie, M.D.)

WASHINGTON — Muhannad Amin, M.D.

SPEAKER OF THE HOUSE — James B. Perry, M.D.

VICE SPEAKER — Franklin B. McKechnie, M.D.

A motion carried to adopt the Rules and Order of Business as listed in the Handbook:

Information for Delegates

The Rules and Order of Business for the House of Delegates are included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. **The By-Laws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance**, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Wherever possible, it is requested that resolutions and supplemental reports be forwarded to the Association's executive office by April 21 for duplication and distribution to the delegates.

Your attention is called to the format of the annual meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House. All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to

FIRST HOUSE OF DELEGATES

allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairman to defer items in which they are interested in order that they may be present to discuss the subject.

All resolutions **must have a sponsor present before the Reference Committee**. Resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be available for distribution by the time the First House convenes. Only the "Resolved" portion of the resolutions will be adopted as policy.

All Reference Committee reports will be duplicated and available to the delegates at the Registration Desk on Saturday morning. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, (as well as those which will be in the Delegates' Packets, and the reports of the Reference Committees) have been printed on colored paper for easy reference. This color code is as follows:

- Reference Committee No. I — Green
- Reference Committee No. II — Buff
- Reference Committee No. III — Blue
- Reference Committee No. IV — Pink
- Reference Committee No. V — Goldenrod

According to our By Laws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

James B. Perry, M.D., Speaker
House of Delegates

Franklin B. McKechnie, M.D., Vice Speaker
House of Delegates

A motion carried to adopt the Minutes of the 1980 House of Delegates as published in the July 1980 issue of *The Journal of the Florida Medical Association*.

The Speaker introduced the officers of the Association: Franklin B. McKechnie, Vice-Speaker; T. Byron Thames, M.D., President; Sanford A. Mullen, M.D., President-Elect; Richard S. Hodes, M.D., Immediate Past President; Gerold L. Scheibler, M.D., Vice President; Robert E. Windom, M.D., Secretary; J. Russell Forlaw, M.D., Treasurer; W. Harold Parham, D.H.A., Executive Vice President.

Dr. Perry advised that during the past year a number of FMA members had departed this life. In memory of these physicians, roses had been placed in the vases at each end of the Speaker's podium. Dr. Perry asked that the House observe a moment of silent prayer in respect and memory of these members.



FMA President-Elect Sanford A. Mullen, M.D., Jacksonville (right), and Vice Speaker of the House Franklin McKechnie, M.D., Winter Park, discuss an item of House business.

Remarks — Speaker of the House

Mr. President, Officers of the Association, Delegates, Honored Guests, fellow physicians, ladies and gentlemen: It is my privilege and honor to address you, my colleagues in the House for the first time from this elected office. I thank each and every one of you for this opportunity and hope that I can fulfill the responsibility entrusted to me as your Speaker.

Although the activities of the House are known to many of you, I should like to review some of the procedures for all so that this, the most important meeting of the year, is completed effectively and with a minimum of effort. As you know, there is at least one delegate from each county society and one delegate for every 50 active members or fraction above that complete unit. There are also medical student delegates, the speaker, and the vice-speaker; together these make up the voting membership of the House. The privilege of the floor is granted to all officers, presidents of county medical societies, Board members, AMA delegates, past presidents of FMA, members of the Council on Specialty Medicine, Council chairmen, AMA general officers, and past presidents who are FMA members. This privilege includes the right of these members to make motions, provided they are seconded by voting members of the House. The presiding officer may grant the privilege of floor to others whenever he deems it necessary.

FMA Bylaws require delegates to fill out attendance cards at each meeting of the House of Delegates to be credited in attendance. The chairman of the Credentials Committee is required to report to the House the number of delegates registered, thus eliminating the necessity of a roll call to seat delegates.

Our deliberations in the House of Delegates, as well as the Board of Governors and all Councils and Committees, are governed by parliamentary usage as contained in Sturgis' Standard Code of Parliamentary Procedure. This will prevail unless otherwise provided by Florida Medical Association Charter or Bylaws, or unless waived or modified by a two-thirds vote of the members present at any session of the general assembly or meeting of the House of Delegates.

To paraphrase Sturgis', the duties of a delegate are to vote first for what he believes is best for the organization as a whole; and secondarily to vote for what is best for the particular group that he represents. He is

FIRST HOUSE OF DELEGATES

to vote for what is best for the particular group that he represents. He is first a legislator for the whole organization and second a spokesman for his particular group. He should know how his constituents feel about a proposal and he must be trusted to follow his own judgement in evaluation and voting on matters as they are presented for decision. All reports and resolutions filed before the deadline at 12 noon on the day of the first meeting of the House will be referred to a Reference Committee by the Speaker at the first meeting of the House of Delegates. Each of you as a delegate is an official of the Florida Medical Association. Collectively, you act as spokesmen and voice of the more than 13,000 FMA members. We encourage all of you to have active participation in the deliberations of the five Reference Committees and encourage active debate by any member of the Association during the course of the hearings which are so important and vital to our Association. The participation requires a significant amount of time, but the personal satisfaction of carrying out this responsibility, the representation of your friends and colleagues makes it well worthwhile. This year the Reference Committees are expanded to six members including the chairman. All may participate in deliberations and be seated on the podium during the committee representation. Only five may vote. The reason for the alternate member is because at the time of so many important decisions over the last several years, invariably because of circumstances beyond anyone's control, members have been absent. This creates a strain on the other members that hopefully will be obviated by this new measure.

It is likely that items of interest in a different Reference Committee could cause a time conflict. Inasmuch as possible, this will be worked out on an individual basis by contacting the chairman of the respective reference committees. Each reference committee has a senior staff person as well as recording secretary and an AMA delegate to monitor, to give advice, or to provide technical information. Council chairmen are to be responsive to the needs of the section of the reference committee discussing their actions and activities over the year and be prepared to complement the discussions and give applicable information to the committee members as well as other people attending the hearing. This information is often vital to them and it helps all concerned to be better informed and have a more pertinent discussion.

After the hearings are concluded the reference committees will go into executive session to prepare their reports. The reports of the reference committees will be presented in final written form to the staff for duplication by Friday at noon. There will be a limited number of copies of these reports available to each County Medical Society delegation by mid-afternoon on Friday.

In an effort to clarify the double negative, the Speaker would like to suggest that in the event a reference committee does not recommend the approval of an item; the report should read "disapproval." In this case, when the original item is before the House, the Reference Committee recommends that you vote "no".

An innovation requested by many of the county delegations in the last year will be implemented. It enables a selected representative from any delegation to meet with the speaker or vice-speaker early on Friday morning to go over the first typewritten draft of reference committee reports. Obviously, this should be only if there are pertinent questions or specific problems in some phase of the report which are of vital interest to a particular county delegation or to a particular individual.

By Saturday morning all of the reports will be available to all delegates and these will be taken up during the second and third meetings of the House.

It is hoped that the detailed discussions will take place in the reference committee hearings. We know that every delegate has the opportunity and privilege of discussing any item at the time that the reference committee makes its recommendations to this House. We do not want to inhibit discussion but the necessity of concise and pertinent remarks is preferred and the basic philosophy must always be majority rule; but minority will always have the opportunity to be heard.



William C. Butscher Jr., M.D., Ocala, is the recipient of the 1981 A.H. Robins Company Award for Outstanding Community Service by a Physician. Dr. Butscher was unable to be present, and his award was accepted for him by Edmond D. Strickland, M.D., Ocala, President of the Marion County Medical Society (center). Also pictured are: Mr. Gerald W. Kerlin of the Robins Company (left) and FMA President T. Byron Thames, M.D., Orlando.

On Sunday after the completion of reference committee reports, nominations for officers, and seconds, lasting two minutes each, will be entertained.

As delegates you have the responsibility of determining the course of the Florida Medical Association for the next year. You are the Florida Medical Association and your policies will prevail. This is a great responsibility and a wonderful challenge and truly a way to lead this Association and ultimately the people of Florida into the decade of the "80's" and to a new lease on life, a new beginning, and out of the duldrums of the "70's". All of this is serious and important. We have to fight to preserve freedom and our system of health care, for the recipients of this care are our patients.

I would like to encourage you to both work hard and play hard. We have gotten away from the feeling of enjoyment and good camaraderie that used to bless our profession prior to the problems of the last ten years. The excitement and challenge of the "80's" should provide productive hours of work with even more productive hours of play and enjoyment. God bless you all.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee No. III for consideration.

Dr. T. Byron Thames, President, assumed the Chair to present the A. H. Robins Company Award for Outstanding Community Service by a Physician. Dr. Thames advised the House that the recipient of the Award, Dr. William C. Butscher Jr., of Ocala, was unable to be present, and the award would be received on his behalf by Dr. Edmond D. Strickland of Ocala. Dr. Thames requested that Dr. Strickland be escorted to the podium by Mr. Gerald W. Kerlin, a representative of the A. H. Robins Company and by Dr. Eugene G. Peek Jr., representing Marion County Medical Society.

**A. H. Robins Company Award
For Outstanding Community Service
By A Physician**

Whereas, William Charles Butscher Jr., M.D., of Ocala, Florida, has assisted thousands of families in the raising and care of their children both professionally and in community service since 1956; and

Whereas, This native of Reading, Pennsylvania, assessing the medical needs of his community, has organized and run a pediatric clinic for indigents and voluntarily given of his time to instruct Public Health nurses of Marion County on pediatric physician assessment and care; and

Whereas, He, as a professor, has enriched the educational pursuits of hundreds of young people through his teachings at the University of Florida College of Medicine and Central Florida Community College, where he was honored by the learning center through a scholarship in his name; and

Whereas, Dr. Butscher has made significant contributions to health care education in his community, and received the Marion County Education Association's "School Bell Award"; and

Whereas, He has served as Medical Director of the Marion County Blood Bank, obtaining training for himself and then introducing new methods to further meet the needs of the community; and

Whereas, He has served on the Board of Directors of the Marion County Hospital District and is a past president of the Marion County Medical Society; and

Whereas, Dr. Butscher has taken a special interest in the learning disabilities of others and has educated the public about the problem and in making available the proper testing facilities for children with such disabilities; and

Whereas, Dr. Butscher, with all his other activities, has maintained a private practice of pediatrics for more than 24 years, respected and loved by patients and parents alike; therefore be it

RESOLVED, That the A. H. Robins Award for Outstanding Community Service by a Physician be presented to William Charles Butscher Jr., M.D., for his many years of service and numerous contributions.

Dr. Strickland expressed his appreciation in behalf of Dr. Butscher for the Award.

Dr. McKechnie, Vice-Speaker, introduced Mrs. Fred P. Swing, President of the Florida Medical Association Auxiliary. Mrs. Swing summarized some of the activities of the Auxiliary during the past year, and said that in a Special Auxiliary Issue of *The FMA Journal* three objectives of the Auxiliary were outlined. These were:

- To support the Impaired Physicians Program through fund raising activities, and to co-sponsor and promote an I.P.P. workshop in Lake Buena Vista.
- To encourage physicians to register and vote.
- To try to increase attendance by physicians at the Annual Meeting.

Mrs. Swing added that over \$17,000 in funds had been raised by the Auxiliary.

Dr. McKechnie then introduced Mrs. Frank C. Coleman, President-Elect of the Florida Medical Association Auxiliary and Mrs. Harry S. Dvorsky, President-



Dade delegates Vincent P. Corso, M.D., Miami (left) and Jack Q. Cleveland, Coral Gables.

Elect, American Medical Association Auxiliary; Dr. Edward R. Annis, M.D., Past President of the AMA; Dr. James W. Walker, Past Officer of FMA and President, PIMCO; Mr. William Flaherty, President; Blue Shield of Florida, Jacksonville; Mrs. Linus W. Hewit, AMA Auxiliary Board Member and Mrs. B. David Epstein, Immediate Past President of the FMA Auxiliary.

Dr. Perry introduced the President, Dr. T. Byron Thames. Dr. Thames addressed the House. (See page 509 for an abstract of the President's address).

Dr. Perry resumed the Chair and announced corrections to the Handbook: The total number of members of this House is shown as 264 but should be 265; and Dade County has 56 delegates, rather than 57 as printed.

Dr. Perry announced the members of the Reference Committees, the assignment of AMA Delegates to the Reference Committees and the times that each Reference Committee would meet.

Reference Committee No. I — Health and Education

H. Quillian Jones Jr., M.D., Chairman, Lee
David R. Arrowsmith, M.D., Okaloosa
Hector R. Mendez, M.D., Orange
Robert Boyett, M.D., Dade
Donald G. Nikolaus, M.D., Pinellas
Joseph F. Sullivan, M.D., (Alternate) Collier
Richard G. Connar, M.D., and William J. Dean, M.D. —
AMA Delegate Advisors

Reference Committee No. II — Public Policy

Warren Lindau, M.D., Chairman, Dade
Charles P. Hayes, M.D., Duval
Robert H. Hux, M.D., Lake
Edward Ackerman, M.D., Orange
John M. Canakaris, M.D., Flagler
Hinson L. Stephens, M.D., (Alternate) Clay
Samuel M. Day, M.D., and Vincent P. Corso, M.D. —
AMA Delegate Advisors

FIRST HOUSE OF DELEGATES

Reference Committee No. III — Finance and Administration

Thomas D. Bartley, M.D., Chairman, Alachua
 Charles F. McConnell, M.D., Escambia
 Thomas R. Busard, M.D., Manatee
 Fred S. Carter, M.D., Martin
 Margaret C.S. Skinner, M.D., Dade
 Jerry Moore, M.D., (Alternate) Broward
 Rufus K. Broadaway, M.D., and Vernon B. Astler, M.D. —
 AMA Delegate Advisors

Reference Committee No. IV — Legislation and Miscellaneous

Arthur L. Eberly, M.D., Chairman, Broward
 John C. Fletcher, M.D., Hillsborough
 Alvin E. Smith, M.D., Volusia
 Charles Dunn, M.D., Dade
 John M. Hamilton, M.D., Pinellas
 Kenneth C. Kiehl, M.D., (Alternate) Sarasota
 Joseph C. Von Thron, M.D., and Francis C. Coleman, M.D. —
 AMA Delegate Advisors

Reference Committee No. V — Medical Economics

Brian P. Gibbons, M.D., Chairman, Brevard
 Faris S. Monsour, M.D., Duval
 Franklin H. Pfeifferberger, M.D., Sarasota
 Manuel L. Carbonell, M.D., Dade

William P. Booras, M.D., Duval
 Luis R. Guerrero, M.D., (Alternate) Palm Beach
 Burns A. Dobbins Jr., M.D. and Eugene G. Peek Jr., M.D. —
 AMA Delegate Advisors

Dr. Perry announced that the assignments of reports and resolutions to Reference Committees were as indicated in the Handbook.

The Vice Speaker announced the assignment of Supplemental Reports and Resolutions which were received too late for inclusion in the Handbook and which had been inserted into the Delegates' packets, as indicated on the reports.

The Speaker announced that there would be a Health Run on Saturday morning at 7:30 a.m., and brought to the attention of the House the dates and times of the Blue Shield Informational Meeting, the FLAMPAC-Auxiliary Luncheon at which Senator Orrin Hatch of Utah would speak; and the President's Reception — Country Western Cookout and Hoedown.

The House recessed at 5:20 p.m. to reconvene on Saturday, May 2, at 3:00 p.m.



The Judicial Council sponsored a luncheon in honor of Vincent P. Corso, M.D., of Miami (second from left), who retired from the Council after 10 years of service, including several years as Chairman. Left to right: James A. Winslow, M.D., Tampa,

current Chairman of the Judicial Council; Dr. Corso; FMA President T. Byron Thames, M.D., Orlando; and President-Elect Sanford A. Mullen, M.D., Jacksonville.

General Session

The General Session of the 107th Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m. on Friday, May 1, 1981, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, by the President, T. Byron Thames, M.D.

Dr. Thames introduced the officers seated at the head table and also recognized Mrs. Nancy Wittenberg, Secretary, Department of Professional Regulation.

Dr. Thames announced the winners of the 1980 Scientific/Educational Exhibit Awards.

1981 Scientific/Educational Exhibit Awards

First Place

"Treatment of Pigmy Rattlesnake Envenomation"
William J. Bailey, M.D., Naples, Florida.

Second Place

"Surgical Treatment of Male Impotence"
Victor Politano, M.D., H. M. Carrion, M.D., and John W. Devine Jr., M.D., Department of Urology and Division of Plastic Surgery, University of Miami School of Medicine and Veterans Administration Hospital, Miami, Florida.

William J. Bailey, M.D., Naples (pictured) won first prize in the scientific exhibit competition. Dr. Bailey's display, entitled "Treatment of Pigmy Rattlesnake Bite 1971-1980", was a popular attraction for exhibit hall visitors.

Third Place

"Genital Herpes Infection in the Female"

Pierre J. Bouis Jr., M.D., and Mitchel S. Hoffman (Medical Student), Department of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa, Florida.

Honorable Mention

"Recent Advances in the Treatment and Evaluation of Ear Disease"

Fredric W. Pullen, II, M.D., Constance L. Cabeza, M.A., Gary Rodriguez, M.S., and Natalie Fernandez-Roque, M.A., Miami Speech and Hearing Center, Miami, Florida.

Honorable Mention

"A New Approach to Surgical Treatment of Patent Ductus Arteriosus in Premature Infants"

Enrique Lopez-Cuenca, M.D., Richard Blank, M.D., Luis Bessone, M.D., Stephen Hiro, M.D., and Dennis F. Pupello, M.D., Tampa, Florida.

Dr. Thames, President, invited Dr. Eugene G. Peek Jr., President of the Florida Medical Foundation, and Mrs. Fred P. Swing, Immediate Past President of the FMA Auxiliary, to come to the podium for the presentation of grants from the AMA-ERF to Medical School



GENERAL SESSION

Deans. Dr. Peek made the following presentations: \$7,297.43 to Dr. William B. Deal, Dean, University of Florida College of Medicine, Gainesville; \$7,007.23 to Dr. Emanuel M. Papper, Dean, University of Miami College of Medicine, Miami; \$7,709.20 to Dr. Andor Szentivanyi, Dean, University of South Florida School of Medicine, Tampa; and \$1,070.78 for the Program in Medical Sciences, Florida State University which was accepted by Dr. William B. Deal.

The President then called Dr. Daniel B. Nunn, Editor of *The Journal of the Florida Medical Association*, to the platform to assist in presenting the awards for the Fourth Annual JFMA Award Contest for County Medical Society Bulletins.

Winners of Fourth Annual JFMA Awards Contest For County Medical Society Bulletins

Category I: General Excellence

Bulletin of the Marion County Medical Society, Henry L. Harrell Jr., M.D., Editor.

Category II: Most Improved Bulletin

Lee County Medical Society Bulletin, edited by Thomas M. Wiley Jr., M.D.

Category III: Best Editorial

Miami Medicine for the editorial entitled "The Forgotten Americans"

by Richard J. Feinstein, M.D., published in the November 1980 issue. Editor: Richard J. Feinstein, M.D.

Special Citation for Continued Excellence in Editorial Writing
Capital Medical Society Newsletter, James K. Conn, M.D., Editor.

Category IV: Best Regular Feature

Miami Medicine—The President's Page by Manuel Carbonell, M.D., and Warren Lindau, M.D., Editor: Richard J. Feinstein, M.D.

Category V: Special Recognition

Miami Medicine — for cover photography (particularly cover photographs contributed by Medical Student, Peter A. Van Houten), Richard J. Feinstein, M.D., Editor.

The Bulletin of the Hillsborough County Medical Association for the series "Read and Reflect", Lou Cimino, M.D., Editor.

The contest judges noted with considerable pleasure the rebirth of *The Stethoscope*, the bulletin of the Volusia County Medical Society, after an absence of several years. *The Stethoscope* is looking better than ever under the able editorship of Dr. R. G. Lacsamana. It was noted, however, that the bulletin did not reappear in time to enter the Fourth Annual Awards Contest, but the judges hoped they would have the opportunity to review entries from this excellent publication next year.

Dr. Nunn presented the original cover of the theme issue on "Stress and Lifestyle" to Dr. Thames.



Checks totaling more than \$23,000 in AMA-ERF contributions were distributed to Florida's medical school deans by Eugene G. Peek Jr., M.D. (far right), President of the Florida Medical Foundation. Pictured left to right are: FMA President T. Byron Thames, M.D.; Andor Szentivanyi, M.D., Dean of the University

of South Florida College of Medicine, Tampa; E.M. Papper, M.D., Dean of the University of Miami School of Medicine, Miami; William B. Deal, M.D., Dean of the University of Florida College of Medicine, Gainesville; and Dr. Peek.



Journal Honors County Bulletins

The winners in the Fourth Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins received their plaques at the Friday General Session from FMA President T. Byron Thames, M.D., with the help of JFMA Editor Daniel B. Nunn, M.D. Top photo: Thomas M. Wiley, M.D., Editor, *Lee County Medical Society Bulletin*; James K. Conn, M.D., Editor, *Capital Medical Society Newsletter*; Louis E. Cimino, M.D., Editor, *Hillsborough County Medical Association Bulletin*; Richard J. Feinstein, M.D., Editor, *Miami Medicine*; and Dr. Thames. Lower left: Dr. Nunn, Warren Lindau, M.D., President, Dade County Medical Association; Manuel L. Carbonell, M.D., Immediate Past President DCMA; and Dr. Thames. Lower right: Dr. Nunn; Henry L. Harrell Jr., M.D., Editor, *Marion County Medical Society Bulletin*; and Dr. Thames.





Mr. Steve Baker of Disney World presented the program for the Friday morning General Session. Baker discussed Disney's Experimental Prototype Community of Tomorrow.

Dr. Thames introduced Mr. Steve Baker of the Epcot Center at Disney World.

Under construction now, Epcot Center will open October 1, 1982. It will feature two themed areas, Future World and World Showcase.

The \$800 million project will cover about 600 of nearly 28,000 acres in the Walt Disney World vacation resort. It is the largest project ever undertaken by the Disney organization, and is expected to host eight to ten million guests during its first year. Walt Disney World has already entertained more than 115 million guests since opening in 1971.

Epcot Center will combine future technologies with Disney entertainment skills on a scale never before possible. It will include participation by major corporations and countries from around the world.

The present Walt Disney World Magic Kingdom is 2½ miles north of Epcot Center, and will be linked to it by monorail. The new project also will include its own parking, service and transportation facilities.

Epcot Center is the continuing realization of Walt Disney's great dream for a community of creative concepts for the future where the best ideas of industry, government and academia can be showcased together.

New technologies and prototype concepts have been incorporated into Walt Disney World since the earliest planning more than 15 years ago and throughout Phase I — the Vacation Kingdom. Included are new transportation, communications and safety systems; solar and biomass energy experiments, and innovative master-planning and agricultural developments.

It will be as far advanced from the Disneyland concept as Disneyland was from the old-fashioned amusement park. "In Epcot Center, the 21st century will begin October 1, 1982. Like all of Walt Disney World," Baker added, "Epcot Center will always be in a 'state of becoming,' changing and presenting new ideas in dramatic ways to showcase the technological advancements of tomorrow's world."

Invocation for 107th Annual Meeting

Heavenly Father, we bow our heads in humbleness and raise our spirits in love, and pray that You bless this assembly, so we can perform our duties and partake our deliberations in the next few days with a clear mind, devoid of selfish motives and only considering the benefit of our patients and the needs of the people of our state.

Inspire us with love for our art and for Your children. Do not allow thirst for profit, or ambition for renown and admiration to interfere with our profession. For these are the enemies of truth and can lead us astray in the great task to which we have dedicated our lives.

Preserve the strength of our bodies and soul that we may be ever ready to help the rich and poor, good and bad, enemy as well as friend. In the sufferer, let us see only the human being.

We also pray that You will inspire and direct our leaders so their judgment and decisions be wise and tempered with your merciful justice.

Finally, Dear Lord, we pray that Your face shine upon all of us, so we can always be able to fulfill Your will and live our days in spiritual peace.

—Amen

Auxilians Get Into The Act



Members of the FMA Auxiliary held their annual meeting April 29-May 2. Among the highlights of the meeting was the presentation of the Past President's Pin, presented to outgoing President Mrs. Fred Swing (left in photo #1) by her predecessor, Mrs. B. David Epstein. In photo #2, Mrs. Swing is shown receiving a framed copy of the March 1981 cover of *The Journal of the FMA* from Editor Daniel B. Nunn, M.D. The issue featured articles explaining the myriad activities of the Auxiliary.

1



2



Mrs. Harry Dvorsky, AMA Auxiliary President (back row, far right) installed the new officers of the FMA Auxiliary as Mrs. Linus Hewit, Chairman of the Committee for Long Range Planning (back row, left), and Mrs. Fred Swing, Immediate Past President FMAA (back row, center) looked on. New officers are (front row, left to right): Mrs. Rex Orr, District Vice President, St. Petersburg; Mrs. Guy T. Selander, Dis-

trict Vice President, Jacksonville; Mrs. Charles Stump, District Vice President, Daytona Beach; Mrs. Jack McDonald, District Vice President, Tallahassee; Mrs. N. Harry Carpenter, Recording Secretary, Ft. Lauderdale; Mrs. Milton Tignor, Treasurer, North Palm Beach; Mrs. Laurin Smith, First Vice President, Orange Park; and Mrs. Daniel B. Nunn, President-Elect, Jacksonville.



3



5



Newly installed FMA Auxiliary President Mrs. Frank Coleman (left in photo #3) pauses in her conversation with Auxiliary President-Elect Mrs. Daniel B. Nunn for the *Journal's* photographer. During the Auxiliary confab, Mrs. Albert Gutierrez of Tampa (center in photo #5) was presented with the Peggy Wilcox Award for outstanding service to the Auxiliary. With Mrs. Gutierrez are (left) Mrs. Martin Adelman, 1980-81 President of the Hillsborough County Medical Association Auxiliary, and Mrs. Ferdinando Vizzi, 1980-81 Chairman of the State Health Careers Committee. In photo #4, Immediate Past President Mrs. Fred P. Swing (left) presents the President's Pin to newly installed President Mrs. Frank Coleman, and Mrs. Coleman (photo #6) accepts the President's gavel from Mrs. Swing.



6

Second House of Delegates

The Second Meeting of the House of Delegates convened at 3:00 p.m., Saturday, May 2, 1981, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with Dr. James B. Perry, Speaker of the House, presiding.

Dr. Reginald Stambaugh, Chairman of the Credentials Committee, reported that 240 Delegates were present with 39 component county societies represented, constituting a quorum, and moved that the delegates be seated. The motion carried.

Delegates

- ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; William B. Deal, M.D.; William T. Hawkins, M.D.; Douglas O. Jenkins, M.D.; Diane M. Zabak, Student Delegate (Absent — Edward R. Woodward, M.D.)
- BAY — Philip Cotton, M.D. (Absent — William G. Bruce, M.D.)
- BREVARD — Richard N. Baney, M.D.; Walter J. Cerrato, M.D.; Michael J. Foley, M.D.; Brian P. Gibbons, M.D.; Francis S. Pooser, M.D.; Robert J. Sarnowski, M.D.
- BROWARD — Charles H. Bechert II, M.D.; Joseph A. Benenati, M.D.; Robert L. Berger, M.D.; Robert C. Bishop, M.D.; Anna M. Blenke, M.D.; Robert J. Brennan, M.D.; Andre S. Capi, M.D.; Philip A. Caruso, M.D.; David A. d'Alessandro, M.D.; Burns A. Dobbins, M.D.; Arthur L. Eberly, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; William C. Hartley, M.D.; David C. Lane, M.D.; George P. Messenger, M.D.; Jerry D. Moore, M.D.; Thomas F. Regan, M.D.; William Richman, M.D.; Richard D. Shafron, M.D.; Herbert M. Todd, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Harry B. Weinberg, M.D.; Juan S. Wester, M.D. (Absent — James A. Jordan, M.D.; Orlando Maytin, M.D.; Alexander E. Molchan, M.D.)
- CAPITAL — Merton L. Ekwall, M.D.; Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; Robert N. Webster, M.D.; George N. Lewis, M.D.
- CHARLOTTE — Thomas Civitella, M.D.; Joseph R. Goggin, M.D.; Jaime Torner, M.D.
- CITRUS-HERNANDO — W. Randall Jenkins, M.D.; Clinton J. McGrew, M.D.
- CLAY — Hinson L. Stephens, M.D.
- COLLIER — Allen S. Weiss, M.D. (Absent — Virgil A. Ponzoli, M.D.; Joseph F. Sullivan, M.D.)
- COLUMBIA — Jose Goyenechea, M.D.
- DADE — Joseph Allison, M.D.; Edward R. Annis, M.D.; Jerome Benson, M.D.; Jose S. Bocles, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; Edmund Cava, M.D.; Manuel L. Carbonell, M.D.; Richard C. Clay, M.D.; Jack Q. Cleveland, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Augusto Fernandez-Conde, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; George R. Gage, M.D.; Julian H. Groff, M.D.; James D. Hanson, M.D.; Joseph Harris, M.D.; Herbert S. Kaiser, M.D.; Norman M. Kenyon, M.D.; Norman Korman, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Roberto L. Maury, M.D.; Charles A. Monnin, M.D.; Miguel A. Mora, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Arthur Radin, M.D.; William E. Riemer, M.D.; Walter W. Sackett, M.D.; Oscar Sandoval, M.D.; Daniel Seckinger, M.D.; Everett Shocket, M.D.; M. David Sims, M.D.; Margaret C.S. Skinner, M.D.; Douglas Slavin, M.D.; Leonard S. Sommer, M.D.; Chauncey M. Stone, M.D.; Charles F. Tate Jr., M.D.; John C. Turner, M.D.; Thomas B. Turner, M.D.; Emilio A. Trujillo, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Steven M. Weissberg, M.D.; Elliot Witkind, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; Jim Deming, Student Delegate (Absent — Walter C. Jones III, M.D.; Miguel Milian, M.D.)
- DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.
- DUVAL — Gaston J. Acosta-Rua, M.D.; Harvey E. Bernhardt, M.D.; William P. Booras, M.D.; James L. Borland, M.D.; Yank D. Coble Jr., M.D.; Patricia C. Cowdery, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Emmet F. Ferguson Jr., M.D.; Charles P. Hayes Jr., M.D.; Charles W. Lewis Jr., M.D.; John F. Lovejoy Jr., M.D.; Charles F. McIntosh, M.D.; Faris S. Monsour Jr., M.D.; Daniel B. Nunn, M.D.; Guy T. Selander, M.D.; George S. Trotter, M.D.; James W. Walker, M.D.)
- ESCAMBIA — Paul T. Baroco, M.D.; Rae W. Froelich, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; Theodore J. Marshall, M.D.; C. Fenner McConnell, M.D.
- FLAGLER — John M. Canakaris, M.D.
- FRANKLIN-GULF — Joseph P. Hendrix, M.D.
- HIGHLANDS — Vinod C. Thakkar, M.D. (Absent — Robert T. Rengarts, M.D.)
- HILLSBOROUGH — Francis C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Robert G. Isbell, M.D.; Thomas E. McKell, M.D.; John K. Petrakis, M.D.; J. Robert Qualey, M.D.; Ralph E. Rydell, M.D.; Ronald L. Seeley, M.D.; William W. Trice, M.D.; Harold L. Williamson, M.D.; James A. Winslow Jr., M.D.; Donald Lofland, Student Delegate (Absent — Richard A. Bagby, M.D.; Ralph M. Stephan, M.D.)
- INDIAN RIVER — (Absent — Donald L. Ames, M.D.; Kip Kelso, M.D.)
- LAKE — Frederick C. Andrews, M.D.; Robert H. Hux, M.D.
- LEE — Cecil C. Beehler, M.D.; Larry P. Garrett, M.D.; John S. Hagen, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.
- MADISON — no delegate submitted
- MANATEE — Thomas R. Busard, M.D.; Julian Giraldo, M.D.; Roger A. Meyer, M.D.; Michael G. Ryan, M.D.
- MARION — C. Brooks Henderson, M.D.; James L. McLaughlin, M.D.; Samuel L. Renfro, M.D.
- MARTIN — Fred S. Carter, M.D. (Absent — Robert D. Baratta, M.D.)
- MONROE — Robert Carraway, M.D.; Ronald H. Chase, M.D.
- NASSAU — (Absent — Jose L. Castillo, M.D.)
- OKALOOSA — David R. Arrowsmith, M.D.; Samuel M. Atkinson Jr., M.D.
- ORANGE — Edward Ackerman, M.D.; Clarence H. Brown III, M.D.; Manuel J. Coto, M.D.; Clarence M. Gilbert, M.D.; Alberto J. Herran, M.D.; David L. Mackey, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; James F. Richards Jr., M.D.; James J. Schoeck, M.D.; Edward W. Stoner, M.D.; T. Byron

Thames, M.D.; Robert B. Trumbo, M.D.; Cecil B. Wilson, M.D.
 OSCEOLA — Gilberto Perez, M.D.
 PALM BEACH — Vernon B. Astler, M.D.; Richard C. Cavanagh, M.D.; John D. Corbitt Jr., M.D.; Jerry F. Cox, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V.A. Marks, M.D.; R. Benjamin Moore, M.D.; Reginald J. Stambaugh, M.D.; Ben R. Thebaut Jr., M.D.; Dick L. Van Eldik, M.D.
 PANHANDLE—Herbert E. Brooks, M.D.; K. Sinclair Franz, M.D.
 PASCO—David A. Johnson, M.D.; Robert D. May, M.D.
 PINELLAS—William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay Knight Hanley, M.D.; David S. Hubbell, M.D.; Harold L. Ishler Jr., M.D.; Morris J. LeVine, M.D.; Jack A. MacCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Bruce P. Smith, M.D.; Walter H. Winchester, M.D. (Absent — Michael H. Diamond, M.D.)
 POLK — Thomas M. Caswall, M.D.; John W. Grotfelty, M.D.; Wiley E. Koon, M.D.; Stanley W. Lipinski, M.D.; Thomas E. McMicken, M.D.; John C. Moore Jr., M.D.; David Stoler, M.D.; Paul A. Tanner Jr., M.D.
 PUTNAM — Anne Beynitzky, M.D.
 ST. LUCIE-OKEECHOBEE — Charles R. Cambron, M.D.; William H. Meyer Jr., M.D.
 SANTA ROSA — David B. Young, M.D.
 SARASOTA — John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Keihl, M.D.; Martin F. Mihm, M.D.; Franklin H. Pfeiffenberger, M.D.; Richard C. Reymeyer, M.D.; Karl R. Rolls, M.D.
 SEMINOLE — Luis M. Perez, M.D.; Frederick J. Weigand, M.D.
 SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Andrew C. Bass, M.D.)
 TAYLOR — (Absent — John H. Parker, M.D.)
 VOLUSIA — Grandy B. Barnard, M.D.; Charles R. DeArmas, M.D.; William R. Jones, M.D.; Remigio G. Lacsamana, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.
 WALTON — (Absent — Howard F. Currie, M.D.)
 WASHINGTON — Muhannad Amin, M.D.
 SPEAKER OF THE HOUSE — James B. Perry, M.D.
 VICE SPEAKER — Franklin B. McKechnie, M.D.

Dr. Thames introduced Dr. Vernon B. Astler who spoke on the status of malpractice insurance in Florida.

Dr. Sanford Mullen read a telegram which had been received from Dr. Thames' partners, congratulating him on his year as President of the Florida Medical Association.

Dr. Perry then requested Dr. Thames, President, to present the Distinguished Layman Award, which had been awarded to Representative J. Hyatt Brown in recognition of his help in the Recovery of Costs legislation. Representative Brown was escorted to the podium by Dr. C. Robert DeArmas Jr., President of the Volusia County Medical Society, Dr. James G. White and Mrs. Beebe White.

Distinguished Layman Award Mr. J. Hyatt Brown

Whereas, J. Hyatt Brown, a native son of Florida, born July 12, 1937, in Orlando, Florida, graduated from Mainland High School in



Hon. J. Hyatt Brown of Daytona Beach, former Speaker of the Florida House of Representatives, received the FMA Distinguished Layman Award at the Annual Meeting. Mr. Brown was cited for, among other things, his work in the Legislature to address the problems of professional liability. Shown with him are Mrs. James G. White of Ormond Beach, Auxiliary Legislative Chairman, and FMA President T. Byron Thames, M.D., Orlando.

1955 with honors, was the recipient of B.S. and B.A. degrees from the University of Florida in 1959; and

Whereas, Mr. Brown did distinguish himself at the University of Florida as President of Phi Delta Theta Fraternity, and as a member of the Florida Blue Key Honorary Society and is in the University Hall of Fame; and

Whereas, This dynamic young Floridian did proceed to establish the insurance firm of Brown and Brown in Daytona Beach in 1961; was recognized by his business peers in the community by being selected as chairman of the Board of Directors of Flagship First National Bank of Volusia County; and

Whereas, He has served his community at large as president of the Daytona Beach Area Chamber of Commerce, as vice-president and director of the Daytona Beach Kiwanis, the Salvation Army Advisory Council, the YMCA advisory board, the Civic League of the Halifax area, as chairman of the Community Action Agency, chairman of the United Fund, and a member of the board of directors of the March of Dimes; and

Whereas, Mr. Brown did offer himself for service in the State Legislature as a member from District 31 in 1972, being subsequently reelected until he retired in 1980 during which time he served as chairman of the Growth and Energy Committee from 1974 to 1976, as chairman of the Governmental Operations Committee of the House from 1976 to 1978, and in the exalted position as Speaker of the Florida House of Representatives, 1978 to 1980; and

Whereas, His attention to detail and duty were such that in the

period 1977-78 he was selected both as the Most Valuable Member of the House, receiving the St. Petersburg Times Award, and as the Most Effective Member of the House, receiving the esteemed Allen Morris Award, and was named by Time Magazine in 1979 as one of the Nation's Top 50 Leaders; and

Whereas, This articulate legislator continuously demonstrated a clear understanding of the professional liability insurance problems facing the physicians and citizens of Florida, and did, in fact, devote a considerable amount of personal time and effort to studying FMA proposal, recovery of costs, legislation which he helped champion, and in view of the fact that during his tenure organized medicine did always receive a fair hearing in the interest of the health of the citizens of Florida, now; therefore be it

RESOLVED, That the officers, Board of Governors, members and executive staff of the Florida Medical Association, take great pleasure in bestowing upon J. Hyatt Brown the Distinguished Layman's Award for his efforts in behalf of all the people of the State of Florida.

Dr. Thames announced that this year there would be a Special Certificate presented to Mr. Bruce A. Woolery, an original director of PIMCO. Mr. Woolery was escorted to the podium by Dr. Vernon B. Astler.

Certificate of Grateful Recognition Mr. Bruce A. Woolery

Whereas, Bruce A. Woolery, since 1973, has contributed continuously to the medical profession in Florida by:

— Refining and underwriting the Florida Medical Association's Professional Liability Insurance Program as President of the Argonaut

Insurance Company in 1973 after Commercial Union cancelled the group in 1972.

— Diligently pursuing a successful program until 1975 when Argonaut's parent company, Teledyne, decided to dishonor its contract with the FMA.

— Volunteering to assist the FMA and testifying on its behalf during the lengthy Federal Court trial which ensued in the spring of 1975.

— Giving freely of his time and energy to establish the FMA Professional Liability Insurance Trust and its successor, the Florida Physicians' Insurance Reciprocal.

— Serving as an original Director of PIMCO, the management company for the Reciprocal and administrator of the FMA Insurance Programs.

— Assisting with the Reciprocal's negotiations for reinsurance with Lloyd's and other London Underwriters, particularly in the early stages when no American company would provide this reinsurance coverage.

— Traveling from California to Florida almost each month for over five years to provide his services, with very nominal remuneration.

— Suffering a severe myocardial infarction while helping in Florida and resuming his services as soon as he recovered, and

Whereas, Bruce has endeared himself to all of those he has worked with regarding the FMA activities; therefore be it

RESOLVED, That a Certificate of Grateful Recognition be presented as a small token of the warm appreciation that the Officers, Board of Governors, Members, and the Executive Staff of the Association hold for this outstanding gentleman and the services he has rendered — our friend, Bruce Woolery.

Mr. Woolery expressed his appreciation for the award.

Dr. Thames presented the Annual FMA Awards for Excellence in Medical Journalism. He said that making available medical and health information to the public is an invaluable service to organized medicine and physicians, recognizing that it is a type of reporting requiring great technical skill on the part of news people.

Dr. Thames said he was greatly pleased, both as President of the Florida Medical Association, and as a physician, to present the awards in this year's Excellence in Medical Journalism contest. Each of the winning reporters had presented health topics to the public in a way that was easily understandable, medically correct and pertinent to the readers and viewers of the various media. This is not an easy task and yet each of these persons did so and with a human interest element to achieve maximal viewing, reading or listening.

Dr. Thames introduced the three judges who had the difficult task of deciding the best of all the quality pieces entered in the contest — who took time from their busy schedules to attend several long meetings as well as taking home entries to be reviewed.

From the field of radio and television, Mr. Lou Digiusto III, Vice President of the Florida Production Center in Jacksonville, Florida; representing print media, Mr. William Kemp, President of Caraway Kemp Communications of Jacksonville; and from the field of medicine, Dr. Yank Coble, Chairman of the Council on Scientific Activities. Dr. Thames thanked all three judges on behalf of the Association.



Mr. Bruce A. Woolery of California received a Certificate of Grateful Recognition in appreciation for his many contributions to the FMA professional liability insurance program during the past eight years. Left to right: Vernon B. Astler, M.D., Boynton Beach, Chairman of the Board of the Florida Physicians' Insurance Reciprocal; Mr. Woolery; and FMA President T. Byron Thames, M.D., Orlando.



Miami Herald reporters Pat Malone and Ena Naughton were among the winners in the FMA medical journalism awards contest. Here, they receive their awards from FMA President T. Byron Thames, M.D., at the Second Session of the House of Delegates.

For the second time since the contest's beginning, an award outside the regular category was given. This recognition, called the "President's Plaque" is awarded for print or broadcast pieces deemed to be of outstanding community service. The recipient of this prestigious award in 1981 was Mr. Al Ruechel of WBBH Television in Fort Myers. Mr. Ruechel's report, entitled "The Cancer Time Bomb" was an emotional and personal story of his own fears of a cancer that is often hereditary and was found in his family, most recently afflicting Mr. Ruechel's father. Through the reporter's examinations, discussions with his physicians, and a brochure publicizing his series, cancer check-up centers were established in Lee County and more than 65 persons were found to be in the early stages of cancer.

In the regular categories, for which there is an award and a \$500 check for each individual winner and Certificates of Appreciation for the first and second runners-up, Ms. Vicki Verdery of WTLV Television in Jacksonville was declared winner in the television field for her five-part series entitled "Shock Trauma . . . The Next Step in Emergency Medicine?" Ms. Verdery travelled to Baltimore, Maryland, to do part of her research and filming of the center there.

First runners-up in this field were Donna Hanover and Valerie Wadas of WCKT-TV in Miami for their series "Cancer's Price Tag." Ms. Hanover and Ms. Wadas discussed the economic costs of research and treatment. Second runner-up was Bob Opsahl of WFTV in Orlando for his report on Vasectomy, which dealt with both the physical and emotional aspects of the surgery.

"The Miracle Merchants" was the subject of a radio report about the multitudes of diets on the market today that won for Rick Forschner of WJYW in Tampa. The Judges felt the subject was handled with both human interest and a vast amount of accurate information.

First runner-up in radio is Ms. Marshal Timmons of WUSF in Tampa for her timely report on teenage pregnancy. Second runner-up was Mr. Ed Bell of WKTZ in Jacksonville for his stirring series of commentaries.

Newspaper reporting is divided into two categories; those with circulation under 50,000 and those above. In the smaller circulation,

Mr. Bruce Horovitz of *The Jacksonville Journal* took first place for his series on the possibility of Mayo Clinic coming to Jacksonville and a scrapbook of medical articles of current interest in the Northeast Florida area.

First runner-up went to Ms. Mary Lavers of *The Tampa Times* for a well-researched series on midwives. Second runner-up went to Mr. San Rohlfing-Lee of *The Vero Beach Press-Journal* for his scrapbook of articles spanning the year.

In the category of newspapers with a circulation over 50,000, there was a tie and co-winners were declared. Ms. Ena Naughton of *The Miami Herald* for her series on consumer-oriented medical notes called "To Your Health". Sharing the honors with Ms. Naughton was Mr. Patrick Malone, a repeat winner. Mr. Malone, also of *The Miami Herald*, wrote on varied topics and a series on smoking excellently communicated to his readers.

First runner-up was awarded to Mr. Richard Koenig of *The St. Petersburg Times* for articles ranging from controlling medical costs to illustrating a surgeon's long day at the hospital. Second runners-up were Ms. Rosemay Frawley and Mr. Bill Sloat of *The Tampa Tribune* for their series on nursing homes.

Dr. Thames congratulated all of the winners and said that the Florida Medical Association was profoundly grateful to them for their time and efforts in communicating medical and health topics to the public, thereby keeping the residents of Florida well informed.

Dr. Perry announced the winners of the Golf Tournament.

Dr. Perry, Speaker, called on Dr. T. Byron Thames to come to the podium to present the Certificate of Merit and Certificate of Appreciation. Dr. Thames requested Dr. Faris Monsour to escort Dr. Walker to the podium to receive the Certificate of Merit.

Certificate of Merit James W. Walker, M.D.

Whereas, James W. Walker, M.D., does continue to distinguish himself as a dedicated leader of organized medicine in his county society, his specialty organizations, the FMA and AMA; and

Whereas, This esteemed physician was born in Cookeville, Tennessee, on August 16, 1927; attended Vanderbilt University, and was graduated from the University of Tennessee with an M.D. degree; and

Whereas, This eminent gentleman was associated with Duval Medical Center in Jacksonville, Florida, from 1954 to 1956, and the Charity Hospital of Tulane University in New Orleans, Louisiana, from 1957 to 1958; served the Florida Medical Association as Secretary for six years and Treasurer for five years; served the Florida Medical Foundation as Secretary-Treasurer for six years; served as President and Chairman of the Judicial Committee of the Duval County Medical Society; and as a member of the American Medical Association Committee on Nursing; and

Whereas, As a practicing physician until 1976, he contributed endless hours to the service of his profession and community on committees too numerous to mention, including serving as president of his Rotary Club; and

Whereas, During the mid-seventies medical malpractice insurance crisis he did agree to close his private practice and devote full time to serving his fellow physicians as president of the Professional Insurance Management Company, fulfilling its objectives as management company for the Florida Physicians' Insurance Reciprocal; assumed the pioneer presidency of the Physicians Insurance Association of America, a position to which he has twice been elected by physicians from 22 other states; and

Whereas, This Association did honor Dr. Walker in 1977 with its Certificate of Appreciation and now feels that his never-ceasing efforts on behalf of his fellow physicians in the State of Florida are more than deserving of further recognition now; therefore be it

RESOLVED, That the Certificate of Merit be bestowed upon James William Walker, M.D., with the heartfelt thanks and appreciation of the officers, Board of Governors, members and executive staff of the Florida Medical Association.

Dr Walker stated his appreciation for being awarded the Certificate of Merit and introduced his son Bart and wife Mary to the House.

Dr. Thames announced that two Certificates of Appreciation had been awarded this year and called upon Dr. Robert Johnson and Dr. William E. Price to come to the podium to receive the Certificate of Appreciation on behalf of Dr. Laurie L. Dozier Sr., who was unable to be at the meeting.

Certificate of Appreciation Laurie L. Dozier Sr., M.D.

Whereas, Laurie L. Dozier Sr., M.D., has rendered compassionate and outstanding medical care to the citizens of Florida for 52 years; and

Whereas, This dedicated physician was born on January 8, 1900, in Hillman, Georgia; attended Georgia Military College and the University of Georgia and was graduated from the Medical College of Georgia in 1924; and

Whereas, He practiced obstetrics and pediatrics for 17 years, and then, after a serious illness, returned to specialize in internal medicine;



James W. Walker, M.D., Jacksonville (right), received the Certificate of Merit, the Association's highest honor. Dr. Walker served as Secretary and Treasurer of FMA several years until he became President of Professional Insurance Management Company (PIMCO) in 1976. With Dr. Walker is Faris S. Monsour, M.D., Jacksonville, President of the Duval County Medical Society, an office Dr. Walker also once held.

and

Whereas, Dr. Dozier and Mary, his wife of 55 years, have two sons in practice in Tallahassee: L. L. Dozier Jr., M.D., an internist, and R. M. Dozier, M.D., an allergist; and

Whereas, Dr. Dozier, as a Public Health Officer, treated several epidemics of smallpox and diphtheria, and on one occasion treated more than 150 cases in a "pest house" in Jacksonville; and

Whereas, He has been active in the Capital Medical Society and in 1950 helped establish the present Tallahassee Memorial Regional Medical Center; therefore be it

RESOLVED, That the Florida Medical Association Certificate of Appreciation be presented to Laurie L. Dozier Sr., M.D., as a token of gratitude that the officers, members and executive staff of the Association hold for the many years of outstanding service rendered by this fine physician and Southern gentleman.

Dr. Thames called upon Dr. Francis Pooser to come to the podium to receive the Certificate of Appreciation on behalf of Dr. Theodore J. Kaminski, who was unable to be at the meeting.

Certificate of Appreciation Theodore J. Kaminski, M.D.

Whereas, Theodore John Kaminski, M.D., of Melbourne, Florida,



The Certificate of Appreciation was awarded to two FMA members, but neither was able to attend the meeting to receive the award personally. Francis S. Pooser, M.D., Melbourne (left in left picture) receives the award on behalf of the recipient,



Theodore J. Kaminski, M.D., also of Melbourne, from Speaker of the House James B. Perry, M.D. In right photograph, a Certificate for Laurie S. Dozier Sr., M.D., Tallahassee, is accepted by Robert Johnson, M.D., also of Tallahassee.

has practiced and been a medical leader in his community since 1946; and

Whereas, After he graduated from the University of Louisville, Kentucky, and completed his internship at Jackson Memorial Hospital in Miami, he served as a medical officer in the U.S. Army during World War II; and

Whereas, He, as a Mason-Shriner, selected as his private project to assist crippled children and has graciously given of his time to improve the care and hospitalization for them in his community; and

Whereas, Dr. Kaminski has served as a Brevard County Medical Society Delegate to the Florida Medical Association continuously for 26 years, and is an honorary member of the BCMS Board of Governors; and

Whereas, Because his partner, Dr. John Gayden, has been confined to a wheelchair since 1955, Dr. Kaminski has unselfishly given of his time to make hospital rounds, house and nursing home calls, and whatever else was needed for both of them; and

Whereas, He serves as Chief of Staff at the James E. Holmes

Regional Medical Center, helping to establish a comprehensive hospital from its roots when he became the fourth physician on the staff of the former Brevard Hospital in 1946; and

Whereas, He has been an active and supportive civic leader, serving as Chairman of the Board to build Melbourne Civic Center; and

Whereas, He has been a faithful and devoted family practice physician delivering over 2,900 babies; therefore be it

RESOLVED, That the Florida Medical Association, its Board of Governors, officers, members and staff do show a token of the warm affection they individually and collectively hold for Theodore John Kaminski, M.D., by bestowing upon him the Florida Medical Association Certificate of Appreciation.

Dr. Perry, Speaker, requested that members of Reference Committee No. I come to the podium to give their report.



Get set...

FMA Health Run 1981



2



1

While most FMA conventioners were catching a few extra winks on a quiet Saturday morning, some 50 of the more stout-hearted sprang from their racks, donned A-shirts, shorts and jogging shoes and charged off under the rising sun for a date with a time keeper. After all had completed the 5,000 meter "Health Run for Fun", it was evident that for the second year in a row 46-year-old fleet-footed Fenner McConnell, M.D., of Pensacola, was the fastest of them all. He is shown in (5) confirming his winning time with FMA staff member Judy Andrews.

In picture #1, Past President Jack A. MaCris, M.D. (left), compares notes with Karl S. Franz, M.D. (No. 5458) and Victor Doig, M.D. (No. 5460). After the race, *The Journal's* photographer caught Robert H. Threlkel, M.D., deep in thought (picture #2). In picture #3, several runners kibitz while two FMA staffers assemble the final order of finish. When Health Run coordinator James B. Perry, M.D. (picture #4) streaked across the finish line and received his finish number from FMA staffer Kathy Lundy, *The Journal's* camera was there to record it!



3



4



5



Go!

Report of Reference Committee No. I

Health and Education

Dr. H. Quillan Jones Jr., Chairman, and his committee came forward to present the report of Reference Committee No. I — Health and Education.

Report B of the Board of Governors

The Reference Committee moved an amendment to Recommendation B-1. The motion carried.

Recommendation B-1 as amended was adopted.

Recommendation B-2 was adopted.

Recommendation B-3 was adopted.

Report B of the Board of Governors as amended was adopted.

Report B of the Board of Governors T. Byron Thames, M.D., Chairman

Board Actions of Major Importance

Cuban Medical Association Congress—Approved FMA Co-sponsorship for the Sixth Annual Cuban Medical Association Congress to be held at the Sheraton Bal Harbor Hotel, Miami Beach, June 30-July 4, 1981.

The Scientific program has been approved for 32 hours of Category I credit for the AMA's Physician Recognition Award, as well as the FMA CME Program and for Prescribed Credit for the American Academy of Family Physicians.

AMA Resolution on CME — Received as information a report on the actions of the AMA House of Delegates at its meeting in July, 1980, adopting a resolution calling for a moratorium on all additional mandatory continuing education and reexamination or recertification programs pending evidence of their effectiveness in upgrading the competence of physicians.

AMA Awards — Joseph B. Goldberger Award — Nominated Dr. Lewis A. Barnes to the AMA as the recipient of the 1981 Joseph B. Goldberger Award in clinical nutrition.

FMA Councils and Committees

COUNCIL ON SCIENTIFIC ACTIVITIES

1981 Annual Meeting — The Board approved the format for the

1981 Annual Meeting which will have the theme "Stress and Lifestyle" and which will provide an opportunity for physicians to earn 20.75 hours of CME credits.

FMA Journal — The Board expressed commendations for the continuing excellence of the FMA Journal under the leadership of the new Editor, Dr. Daniel Nunn of Jacksonville, and noted with interest future special issues planned including "Stress and Lifestyle", a commemorative issue recognizing the 10th Anniversary of the University of South Florida and a special issue on the FMA Auxiliary.

The Board was also pleased to note that a seven part series on State peer review activities prepared by the FMA Committee on PMUR began with the October issue.

Other features being contemplated include areas of socioeconomics and legislative considerations and articles featuring varying aspects of medical specialties.

AMA Symposium on Diet and Exercise — The Board approved FMA co-sponsorship of the AMA's "Symposium on Diet and Exercise: Synergism in Health Maintenance" which is scheduled to be held at Lake Buena Vista, Florida, November 3-4, 1981.

COUNCIL ON SPECIALTY MEDICINE

Patient Transfers — During the past year the Council on Specialty Medicine has been studying the liability aspects of patient transfers. This endeavor was prompted by a report from the Florida Society of Neonatal-Perinatologists regarding problems that were occurring involving transfers to neonate centers. The Council attempted to determine when the referring physician liability terminated and when the receiving physician responsibility commenced. FMA's Legal Counsel provided an opinion that both the referring and receiving physician were liable until the physical transfer of the patient was completed.

The Council then drafted a proposed position on patient transfers in an effort to minimize the potential liability to both the referring and receiving physicians.

RECOMMENDATION NO. B-1

THAT THE FMA ADOPT THE FOLLOWING POSITION CONCERNING PATIENT TRANSFERS:

THE PHYSICIAN REQUESTING THE TRANSFER OF A PATIENT TO A SPECIALIZED MEDICAL FACILITY WILL BE RESPONSIBLE FOR THE CARE OF THE PATIENT UNTIL THE TRANSPORT TEAM DEPARTS THE FACILITY.

UPON DEPARTURE OF THE TRANSPORT TEAM, UNDER THE DIRECTION AND RESPONSIBILITY OF THE ACCEPTING PHYSICIAN, THE REFERRING PHYSICIAN WILL RELINQUISH RESPONSIBILITY OF THE PATIENT'S CARE BY SIGNING A WRITTEN STATEMENT.

THE DECISION TO TRANSFER ANY PATIENT



Reference Committee I studied and reported to the full House of Delegates on matters in the category of Health and Education. Left to right: Robert Boyett, M.D., Miami; Joseph F. Sullivan, M.D., Naples (Alternate Member); Donald G. Nikolaus, M.D.,

Dunedin; Mrs. Diane Bowker of the FMA Tampa Office, Recorder; H. Quillian Jones Jr., M.D., Fort Myers, Reference Committee Chairman; Hector R. Mendez, M.D., Orlando; and David R. Arrowsmith, M.D., Fort Walton Beach.

MUST BE MADE SOLELY BY THE RESPONSIBLE PHYSICIAN AND NO PATIENT SHOULD BE TRANSFERRED WITHOUT PRIOR AGREEMENT OF THE RECEIVING PHYSICIAN AND THE CONSENT OF THE RECEIVING INSTITUTION.

Tuberculin Skin Testing — The Board reaffirmed FMA's support of tuberculin skin testing as a routine skin examination procedure for the detection of TB infection in adults prior to the onset of active disease with the recommendation that those found to be infected either be given preventive drug therapy or evaluated periodically.

The September 1980 issue of *The Journal of the American Medical Association (JAMA)* had carried an editorial which stated that TB testing has little value today because of the low level of TB prevalence. The Board concurred with the opinion of the Florida Society of Preventive Medicine that TB is still a major public health problem in the state of Florida, and that data clearly indicates that skin testing is a productive and efficient procedure for early detection.

Florida Relative Value Studies Update — The Board directed that adequate time be allowed for the Council on Specialty Medicine to provide input requesting revision of the 1975 *Relative Value Study*, particularly for ground rules and modifiers.

X-Ray Technician Certification — The Board reviewed a report indicating that the home study guide for basic X-ray machine operators recommended by the FMA has been adopted by the state and that an appropriate test would soon be developed. In addition, a representative of the Radiological Health Section of the Department of HRS stated that temporary certificates would no longer be allowed after the home study guide and certification test have been published.

RECOMMENDATION NO. B-2

THAT THE FMA ADOPT THE FOLLOWING POSITION ON BASIC X-RAY OPERATOR CERTIFICATION:

1. THAT THE CERTIFICATION EXAMINATION FOR THE BASIC X-RAY OPERATOR BE LIMITED TO SAFETY FACTORS; THAT NO PHYSICS BE INVOLVED OTHER THAN THAT NECESSARY

FOR UNDERSTANDING SAFETY FACTORS: AND THAT THE EXAMINATION BE LIMITED TO THE MATERIAL CONTAINED IN THE STUDY GUIDE; AND FURTHER

2. THAT PROCEDURES BE ESTABLISHED TO FACILITATE STATEWIDE UNIFORMITY IN THE PROGRAM; AND FURTHER
3. THAT THE TEMPORARY CERTIFICATE PROGRAM BE MAINTAINED PRIOR TO THE BASIC OPERATOR EXAMINATION; AND FURTHER
4. THAT ALL OF THE FUNCTIONS PERFORMED BY X-RAY TECHNICIANS BE UNDER THE DIRECT SUPERVISION OF A LICENSED PHYSICIAN.

Physician Extenders — The Board approved in principle a proposal for an independent study regarding physician extenders including:

- projected need
- cost effectiveness
- definition and type of professionals
- definition of direct and responsible supervision by licensed physicians
- appropriate regulation to insure quality of health care

The Board concurred with the council's feeling that physician extenders activities should only be under the direct and responsible supervision of licensed physicians and that training programs be limited to the demonstrated need for physicians related practices. It was also pointed out that problems do exist with regard to definition, certification, and regulation of these assistants in addition to limitations on the extent of their practice. The Board also noted recent statistics forecasting a surplus of physicians within the United States and propositions that have been put forth calling for cessation of support for training of paramedical personnel.

Florida Society of Otolaryngology — Head/Neck Surgery — The Board approved the request of the Florida Society of Otolaryngology to change their name and hereafter be recognized and referred to by the FMA as the Florida Society of Otolaryngology — Head/Neck

Surgery.

Preventive Health Education Program for New Mothers —

The Board reviewed a request from Dr. James T. Howell, state health officer, that the FMA endorse and assist the Department of HRS in publicizing the department's New Mothers Immunization Education Program, currently operating in 37 Florida hospitals. The program is a cooperative effort between HRS and the hospital auxiliary, women's clubs and volunteers of the Florida League of Nursing to educate new mothers on the importance of the immunization of infants and pre-school children as well as the maintenance of personal immunization records.

The department's goal is to have the program operational in all Florida hospitals with maternity facilities.

RECOMMENDATION NO. B-3

**THAT THE FMA ENDORSE THE DEPARTMENT OF HRS
NEW PREVENTIVE HEALTH EDUCATION PROGRAM FOR
NEW MOTHERS.**

Report of the Council on Scientific Activities

The Report of the Council on Scientific Activities was adopted.

Council on Scientific Activities

Yank D. Coble Jr., M.D., Chairman

The 1980-81 Florida Medical Association business year was another busy one for the Council on Scientific Activities and its component Committees on Continuing Medical Education and Scientific Publications. The Committee and Council chairmen and staff consulted frequently and thus were able to limit formal meetings to one during the year.

Major items of business to come to the attention of the Council are summarized below under appropriate headings.

Committee on Continuing Medical Education

The Committee on Continuing Medical Education discharged its duties conscientiously and effectively under the able leadership of Henry M. Yonge, M.D. Major activities during the past year include:

1. **Annual Meeting Scientific Program:** Program chairmen of recognized specialty groups have fashioned an outstanding and comprehensive scientific program for the 107th Annual Meeting of the FMA under the seasoned tutelage of Calvin W. Martin, M.D., Chairman of the Subcommittee on Annual Meeting Scientific Program.

The Subcommittee has been fortunate in engaging Joseph B. Trainer, M.D., Professor of Medicine at the University of Oregon, to present the major address keynoting the "Stress and Lifestyle" theme of the Annual Meeting. Dr. Trainer will address a general session on the subject of "Stresses of the Medical Family" on Thursday, April 30, at 5:30 p.m.

More than 30 scientific sections arranged by state specialty groups will form the backbone of the scientific program, and many of these will include four hours of Pfizer's popular "Dialogue" series, and the Wyeth AutoTutors will be available for self-instruction in the Exhibit Hall, where about 25 scientific and educational exhibits will be on display.

Once again, the Annual Meeting will be co-sponsored by the Medical Education Committee of the Florida Medical Foundation, which has approved the program for 20 hours of AMA Category I Credit. Certain elements of the Annual Meeting Scientific Program



Carlotta Rinke, M.D., the American Medical Association's Morris Fishbein Medical Journalism Fellow, attended the 107th Annual Meeting to report for AMA publications and to witness the operations of a large state medical association. Here she chats with (left to right): Edward R. Annis, M.D., Miami, Past President of the AMA; FMA Secretary Robert E. Windom, M.D., Sarasota; and President T. Byron Thames, M.D., Orlando.

have been approved by the American Academy of Family Physicians for Prescribed Credit.

Florida's three medical schools again are participating in the program as co-sponsors.

2. **Program Approval:** Florida providers of continuing medical education continued their heavy reliance on the FMA's program approval mechanism. This system gives providers access to FMA Mandatory Credit, of which each FMA member subject to the Association's mandatory CME program must report at least 60 hours every three years.

During calendar year 1980, the Subcommittee on Program Approval processed about 380 such applications. In 1981, between January 1 and February 18, 71 applications were received at FMA Headquarters.

3. **Accreditation:** The Committee is delighted that accreditation programs for continuing medical education at the national level once again are unified. The newly-formed Accreditation Council for Continuing Medical Education became operational on January 1 with participation by the American Medical Association, supplanting the separate programs of the AMA and the Liaison Committee on Continuing Medical Education.

The authority of state medical associations to accredit intrastate providers within their boundaries has been affirmed by the new ACCME.

Since the last report of the Council on Scientific Activities was made to the House of Delegates in 1980, the Committee on Continuing Medical Education has taken the following accreditation actions:

- A. **Florida Division, American Cancer Society** — Accredited provisionally for two years (April 18, 1980 to April 17, 1982).
- B. **Boca Raton Community Hospital** — Accredited provisionally for two years (March 28, 1980 to March 27, 1982).
- C. **Bay Pines Veterans Administration Center** — Regular reaccreditation (upon reconsideration) for four years (February 29, 1980 to February 28, 1984).
- D. **Watson Clinic, Lakeland, Fla.** — Accreditation application withdrawn on August 2, 1980.

SECOND HOUSE OF DELEGATES

- E. **Florida Academy of Family Physicians** — Regular reaccreditation for four years (January 7, 1981 to January 6, 1985).
- F. **Sarasota County Medical Society** — Regular reaccreditation for four years (December 12, 1980 to December 11, 1984).
- G. **Orlando Regional Medical Center** — Regular reaccreditation for four years (December 14, 1980 to December 13, 1984).
- H. **Hollywood Memorial Hospital** — Regular reaccreditation for four years (December 14, 1980 to December 13, 1984).
- I. **American Hospital of Miami** — Provisional accreditation for two years (September 24, 1980 to September 23, 1982).
- J. **Florida Lung Association** — Regular reaccreditation for four years (February 9, 1981 to February 8, 1985).
- K. **Tallahassee Memorial Hospital Regional Medical Center** — Regular reaccreditation for four years (January 29, 1981 to January 28, 1985).

Committee on Scientific Publications

The Journal of the Florida Medical Association and the Committee on Scientific Publications have enjoyed an outstanding year under the leadership of Daniel B. Nunn, M.D., in his first year as Editor of *The Journal* and Chairman of the Committee.

Dr. Nunn and his editorial colleagues have been innovative in making *The Journal* more inviting and useful to Florida Medical Association members.

The Committee met three times since the 1980 Annual Meeting — in Jacksonville on May 23, in Atlantic Beach on August 23, and in Tampa on March 7.

Following is a summary of activities:

1. **Special Issues:** The popular and perennial Historical Issue was published in August with the usual excellent planning of Historical Editor William M. Straight, M.D., of Miami. This was followed in September by a widely acclaimed Special Issue on Family Practice produced by the Florida Academy of Family Physicians with the late Cranford O. Plyler, M.D., serving as Guest Editor.

As this report was prepared, a Special Auxiliary Issue was being assembled for March, and the editors looked forward to a symposium-type issue in April on "Stress and Lifestyle" to accent the Annual Meeting theme. Further in the future is another Historical Issue (August 1981) and a Special Issue commemorating the Tenth Anniversary of the University of South Florida College of Medicine (September 1981).

2. **Covers:** The new editorial regime has continued the practice of selecting attractive covers to make issues of *The Journal* inviting to the reader.



Yank D. Coble Jr., M.D., Jacksonville (left), Chairman of the Council on Scientific Activities, chats with Dr. and Mrs. Lee A. Fischer of West Palm Beach.

3. **Editorials:** Efforts are being made to bolster the editorial page, publishing at least one editorial monthly.

4. **New Features:** Several new features have been introduced. These include "Fifty Years Ago", "Today's Issues" and a monthly Auxiliary page. The editorial staff will be pleased to receive suggestions from members.

5. **Budget:** The Council and Committee are most grateful for the moral and financial support given *The Journal* by the Board of Governors. The budget provided for 1981 will enable the Committee to enhance the quality of *The Journal* notwithstanding the printing rate increase that went into effect in February. A large portion of the budgeted funds will be returned to FMA through increased advertising and subscription rates that went into effect in January on recommendation of the Committee and the Council and by action of the Board.

6. **Consulting Editors:** The custom of a joint meeting of the Committee and the Board of Consulting Editors is being continued. This year's meeting was held in Tampa on March 7.

A critique of county medical society bulletins and *The Journal* was provided by Professor Paul Fisher of the University of Missouri School of Journalism.

7. **JFMA Awards Contest:** The Fourth Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins attracted 48 entries in five categories. Winners will be announced during the General Session on Friday, May 1, at the 107th Annual Meeting.

Miscellaneous

1. **Dean's Luncheon:** The Council is honored to be a principal bridge between FMA and the three medical schools. The Council communicates periodically with the three medical school deans regarding medical education, scientific activities, legislation, and other issues of interest and sponsors the annual Dean's Luncheon during the scientific assembly.

2. **AMA Symposium:** The American Medical Association is sponsoring a program entitled "Symposium on Diet and Exercise: Synergism in Health Maintenance" at Lake Buena Vista, November 3-4. The Council has recommended to the Board of Governors that FMA co-sponsor this meeting as requested by AMA.

Report of the Council on Specialty Medicine

The Report of the Council on Specialty Medicine was adopted.

Council on Specialty Medicine Dick L. Van Eldik, M.D., Chairman

The Council on Specialty Medicine held three meetings during this Association year 1980-81, in Orlando, on September 27, 1980, December 13, 1980 and February 22, 1981. The Council's ad hoc committees on X-ray Technician Certification and Patient Transfers held additional special meetings.

Presently the Council is comprised of representatives from 38 specialty groups that meet all the requirements of FMA's recognition program. All the Council's recommendations are contained in the Board of Governor's report. The following is a summary of the Council's activities.

This year a major part of each Council meeting was devoted to the review and consideration of proposed legislation. This is an extremely important activity which helps to avoid conflicts between specialty

REFERENCE COMMITTEE NO. I

groups and is of great value to the FMA in developing legislative positions.

The Council's two ad hoc committees continued to work on matters regarding certification of X-ray technicians and studying the legal ramifications of patient transfers.

A number of subjects involving medical economics such as third party reimbursement for multiple procedures and ambulatory surgical supplies were referred to the FMA Council on Health Care Financing. The Council on Specialty Medicine is closely monitoring the revision of FMA's 1975 Relative Value Studies. The Board of Governors approved the Council's recommendation that adequate time be allowed, within reason, for the Council on Specialty Medicine to review the initial draft of the RVS manual for particular input on ground rules and modifiers.

The Board of Governors approved the Council's recommendation that the FMA establish an Ad Hoc Committee to study in depth the physician extender problem including the projected need, cost effectiveness, definition and types of professionals, definition of direct and responsible supervision by licensed physicians, and types of regulation in order to insure the highest quality health care to the citizens of Florida.

The Florida Society of Otolaryngology requested that the FMA recognize the recent name change in their state organization which is in compliance with the action taken by their national organization. The Council endorsed this request which was formally approved by the FMA Board of Governors. Therefore, the Florida Society of Otolaryngology will hereafter be referred to as the Florida Society of Otolaryngology — Head and Neck Surgery.

Following FMA's reorganization, certain specialty groups were asked to assist the FMA in continuing programs involving sports medicine and maintaining liaison with allied health professions. In response to this request, the Florida Orthopedic Society has submitted to the Council recommendations regarding school athletics and is presently establishing a liaison committee to meet with the Florida Chapter of the American Physical Therapy Association.

The Council has made recommendations in opposition to federal subsidies for health maintenance organizations and the continuation of health systems agencies. It supports the elimination of all requirements for certificates of need in the health care field.

At the request of the Council on Specialty Medicine, the FMA has forwarded to each recognized Specialty Group a copy of the Graduate Medical Education National Advisory Committee report (GMENAC) to the Department of Health and Human Services. This study identifies medical specialty surpluses and shortages, and recommends physician/population ratios. The findings and recommendations of the GMENAC report may have a major impact on future allocations of funds and resources for graduate medical education. The FMA has requested that each specialty group review this report and submit their comments to the Council on Specialty Medicine.

The Council on Specialty Medicine has concluded another successful year which provided all recognized specialty groups a forum with direct input to FMA programs and policies. While the 38 specialty groups have diverse interests and goals, they recognize their responsibility as entities of organized medicine and stand united with their state medical association.



Among the regulars attending this year's Annual Meeting were Dr. and Mrs. Emmet Ferguson Jr., of Jacksonville.

Report of the Florida Medical Foundation

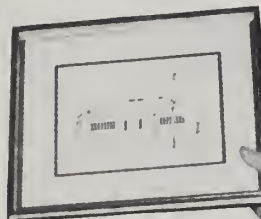
The items in the Florida Medical Foundation Report on Medical Education Committee, Medical Student Loans and Nutrition Textbook were adopted. (See Report of the Florida Medical Foundation on page 563).

RESOLUTION 81-1 Continuing Medical Education Broward County Medical Association

Resolution 81-1 was not adopted.

The Chairman expressed his appreciation to all members of the Association who provided guidance and counsel. Special thanks was conveyed to Dr. William J. Dean who represented the AMA Delegates at the meeting of the Reference Committee, and Dr. Jones also expressed his sincere appreciation to the members of the committee and to the FMA staff, Mr. Edward Hagan and Mrs. Diane Bowker, for their assistance in the preparation of the report.

The motion of the Reference Committee that the Report of Reference Committee No. I be adopted as amended carried.



Editor's Dinner

Editors of *The Journal* gathered on Wednesday evening of the Annual Meeting for their yearly dinner, after which they strolled to the Exhibit Hall to select the winner of the Editor's Award in the FMAA Art Exhibit.

Presiding over the annual gathering was Editor Daniel B. Nunn, M.D., shown above holding a framed drawing of his office that signals the end of each month's editorial section. Associate Editor and Mrs. Clyde M. Collins, M.D. (upper left) were in a happy mood, as were FMA

President-Elect and Mrs. Sanford A. Mullen, M.D., pictured at left with medical student editor James Deming of the University of Miami School of Medicine.

Below, Mrs. Nunn and Historical Editor William M. Straight, M.D., enjoy the after-dinner program.



Shown above are some of the notables who attended the Editor's Dinner. Front row: Medical student editor James Deming, Miami; Yank D. Coble Jr., M.D., Chairman of the Council on Scientific Activities; *JFMA* Editor Daniel B. Nunn, M.D.; and Assistant Editor Lee A. Fischer, M.D. Standing: Historical Editor William M. Straight, M.D.; Book Editor F. Norman Vickers, M.D.; Associate Editor Clyde M. Collins, M.D.; Assistant Editor Francis C. Coleman, M.D.; and Associate Editor E. Charlton Prather, M.D.



Report of Reference Committee No. II

Public Policy

Dr. Warren Lindau, Chairman, and his committee on Public Policy came forward to present their report.

Report C of the Board of Governors

The motion of the Reference Committee that the item relating to Flagging Student Health Records be amended by deleting the word "Flagging" from the subject heading carried.

The item relating to School Health Records was adopted as amended.

Dr. Lindau stated there would be a Minority Report of the Reference Committee on the item "Licensure of Public Health Officers".

The Reference Committee moved an amendment to the item on Licensure of Public Health Officers by adding the words "with minimum standards".

An amendment to the Reference Committee's motion was moved from the floor to read: "... with minimum standards of an M.D. and a Masters Degree in public health and a minimum of 10 years experience in the public health field". The amendment failed to carry, and the original amendment of the Reference Committee

failed to carry.

The minority report was presented by Dr. Ackerman and Dr. Hux.

Minority Report Licensure of Public Health Officers

"Mr. Speaker, we who differ from the majority opinion would like to state the basis for our objections to the Board of Governors approval in principle of the development of a limited licensure of physicians. We feel that if clinical responsibilities are required and patients are to be treated, then the requirements must be the same for all practitioners of medicine.

"We are opposed to the creation of multiple classes of licensure of physicians. All physicians practicing medicine should have a license to practice medicine and be judged by the same standards as all other physicians who treat patients."

A motion to adopt the minority report of Reference Committee No. II carried.

A motion to delete from the Board of Governors Report C the paragraph on "Licensure of Public Health Officers" carried. Report C of the Board of Governors was adopted as amended.



Reference Committee II heard testimony on FMA business in the area of Public Policy. Left to right: Robert H. Hux, M.D., Leesburg; Charles P. Hayes, M.D., Jacksonville; Warren Lindau, M.D., Miami, Chairman; Mrs. Leah Beal, Recorder;

Samuel M. Day, M.D., Jacksonville, AMA Delegate Advisor; Edward Ackerman, M.D., Winter Park; and John M. Canakaris, M.D., Bunnell.

SECOND HOUSE OF DELEGATES



All three of Florida's medical school deans attended the annual Dean's Luncheon, hosted by the FMA Council on Scientific Activities. Left to right: FMA Secretary Robert E. Windom, M.D., Sarasota; President T. Byron Thames, M.D., Orlando; Yank D. Coble, M.D., Jacksonville, Chairman of the Council on Scientific Activities; E.M. Papper, M.D., Miami, Dean of the University of Miami School of Medicine; Calvin W. Martin, M.D.,

Arcadia, Acting Chairman, FMA Committee on Continuing Medical Education; William B. Deal, M.D., Gainesville, Dean, University of Florida College of Medicine; Daniel B. Nunn, M.D., Jacksonville, Chairman of the FMA Committee on Scientific Publications; and Andor Szentivanyi, M.D., Tampa, Dean, University of South Florida College of Medicine.

Report C of the Board of Governors T. Byron Thames, M.D., Chairman

FMA Councils and Committees

COUNCIL ON MEDICAL SERVICES

State Emergency Medical Services Program — The Board approved continued efforts to develop a contractual agreement between the Department of HRS and the Florida Medical Foundation for providing the State EMS Office a Medical Director and giving the Foundation the responsibility for planning and development of State EMS Programs.

School Entry Medical Examination — The Board approved a recommendation to the Department of Education and the Health Program Office, DHRS, that only M.D.'s and D.O.'s be accepted to certify that a medical or physical examination has been completed under the school entry medical examination law.

Student Health Records — The Board requested that a letter be sent to recognized voluntary health agencies requesting the development of guidelines for handling student chronic health problems or to provide the FMA with information on any such material already in existence.

Governor's Council on Drug Abuse — The Board recommended to Florida Governor Bob Graham that consideration be given to re-establishing the Governor's former Council on Drug Abuse. It was noted that with the reorganization of DHRS the Council had been transferred to the Mental Health Office and had since not been able to obtain priority status, funding or the visibility necessary to conduct an effective program.

Administrative Medicine Committee — The Board concurred

in the Council's recommendation that the FMA Administrative Medicine Committee be dissolved, as alternative, effective communications and liaison already exists through other mechanisms with the organizations served by the Committee.

Licensure of Public Health Officers — (Deleted)

FMA Health Run — The Board approved FMA sponsorship of the Third Annual Health Run (3.1 miles) to be held in conjunction with the 1981 FMA Annual Meeting.

Report of the Council on Medical Services

The Report of the Council on Medical Services was adopted.

Dr. Lindau expressed appreciation to Dr. Joseph T. Ostroski, Chairman, and his Council on Medical Services on the great deal of work they had done through the year.

Council on Medical Services Joseph T. Ostroski, M.D., Chairman

During this reporting period the Council on Medical Services held two meetings. Four committees make up the Council and are responsible for a broad range of subjects dealing with the delivery of medical care in Florida. All the Council's recommendations are contained in the Board of Governor's report. The following is a consolidated report of the Council's activities.

The Committee on School Health, chaired by Wesley S. Nock, M.D., continues to serve as an advisory committee to the Department of Education and Health Program Office, Department of Health and Rehabilitative Services.

This year the Committee held quarterly meetings and made recommendations concerning increased funding for school health services.

flagging student health records for chronic conditions, the State Immunization Law and the new school entrance medical examination statute.

Other subjects considered included school screening programs, handling school emergencies, teacher health education curriculum and FMA's co-sponsorship of the 1980 Florida School Health Conference.

The **Committee on Emergency Medical Services**, chaired by Roy M. Baker, M.D., held two general meetings and conducted a number of special meetings on specific programs. Recommendations were made concerning the FMA's critical care study, sponsorship of a state-wide conference on critical care and the State EMS Program.

This year the Committee's major effort was the development of a comprehensive proposal to have the Florida Medical Foundation contract with the Department of Health and Rehabilitative Services for providing certain services to the State EMS Program. These services would include a medical director for the State EMS office and the medical planning and development for all State EMS programs. Presently, the proposal is being discussed with representatives of the Department of Health and Rehabilitative Services and members of the Legislature.

The **Committee on Administrative Medicine**, chaired by Charlotte E. Maguire, M.D., is composed of representatives from the Florida Hospital Association, Florida League of Hospitals and the Group Management Association. The purpose of the Committee is to maintain liaison between the FMA and these organizations. The Committee's major goal has been to establish better communications, and this has been achieved by exchanging general publications (newsletters, etc.) that are produced by each organization. Coordination of legislative programs is another goal of the Committee.

The **Committee on Drug Abuse**, chaired by Robert P. Johnson, M.D., held three meetings and made recommendations concerning state legislation, reactivation of the Governor's Drug Abuse Council and changing the name of the State Mental Health Office to the Office of Drug Abuse/Alcohol and Mental Health for the purpose of placing more emphasis and funding for drug abuse programs.

During the past year, the Committee has submitted two drug abuse articles to *The Journal of the Florida Medical Association*. One article was on prison drug abuse programs and was published in the December issue. The other article concerns how physicians can avoid having their prescription pads stolen and was recently submitted for consideration.

The **AMA Jail Project** technical assistance program will be discontinued this year because of the elimination of federal funding. For two years the Council on Medical Services has served as an advisory body for this program in Florida and is proud of the progress demonstrated by the twelve jails that participated in the project. One jail has recently received a full two-year AMA accreditation and three more are close to achieving this goal. All of the remaining jails have improved the health care services in their respective institutions which was the major goal of this program. Nevertheless, the AMA jail project will continue to offer an accreditation process for any interested jail that can meet the standards that have been developed since the inception of the AMA project in 1975.

RESOLUTION 81-4

National Standardized Immunization Form Escambia County Medical Society

The Reference Committee's motion to amend Resolution 81-4 by deleting the word "such" in the first Resolved carried.

Resolution 81-4 was adopted as amended.



U.S. Sen. Orrin G. Hatch (R-Utah) (second from left) was the featured speaker for the Annual FLAMPAC/Auxiliary Luncheon on Friday of the Annual Meeting. Left to right: FMA Secretary Robert E. Windom, M.D., Sarasota; Senator Hatch; Francis C. Coleman, M.D., Tampa, President of the Florida Medical Political Action Committee (FLAMPAC); and FMA President T. Byron Thames, M.D., Orlando.

RESOLUTION 81-4

National Standardized Immunization Form

RESOLVED, That the Florida Medical Association embrace the concept of a standardized immunization form; be it further

RESOLVED, That the Florida Medical Association work through its legislative and other committees to encourage the State Legislature to approve such a standardized national immunization form for Florida.

RESOLUTION 81-5

Physician's Assistants Brevard County Medical Society

The Reference Committee recommended Resolution 81-5 not be adopted.

A motion to refer Resolution 81-5 to the Board of Governors for further consideration carried.

RESOLUTION 81-5

Physician's Assistants

[Not Adopted — Referred to the Board of Governors]

Whereas, The State of Florida has passed Statute 458.135 governing Physician's Assistants; and

Whereas, The initial intent of the Physician's Assistant law was to provide a new category of health manpower extenders in areas with shortages of health care services because of geographic maldistribution; and

Whereas, Physician's Assistants skills are frequently employed in urban, as opposed to rural communities; and

Whereas, These same services could be rendered by trained tech-

SECOND HOUSE OF DELEGATES

nicians and other health professionals at less cost to our patients; and
Whereas, The people of the State of Florida deserve the highest level of medical care; therefore be it

RESOLVED, That the Board of Medical Examiners limit all new Physician's Assistants certificates to be used in low physician density areas, thus providing increased health care delivery in rural areas and simultaneously decrease their cost effectiveness in urban areas; be it

RESOLVED, That physicians who employ a Physician's Assistant must be present on the premises when the Physician's Assistants are involved in patient care; be it further

RESOLVED, That the employing physician should actively and properly identify the Physician's Assistant; be it further

RESOLVED, That there should be no presigned prescriptions available; be it further

RESOLVED, That patients requiring referral should be examined by the employer physician prior to referral.

RESOLUTION 81-8

FDA Opinions on Drugs

Broward County Medical Association

Since no sponsor had appeared before the Refer-

ence Committee in support of Resolution 81-8, the Reference Committee did not consider it; therefore, Resolution 81-8 was not adopted.

The Reference Committee expressed its appreciation to all members of the Association who appeared at the meeting to provide guidance and counsel.

Special thanks was conveyed to Dr. Samuel Day and Dr. Vincent Corso who represented the AMA Delegates at the meeting of the Reference Committee. Dr. Lindau expressed his sincere appreciation to the members of his Committee.

The Reference Committee also thanked the Speaker and Vice Speaker for their trust and confidence in appointing each of them to the Committee and Dr. Lindau expressed appreciation to FMA staff for their assistance in the preparation of the Committee's Report.

The motion that the Report of Reference Committee No. II be adopted as amended carried.

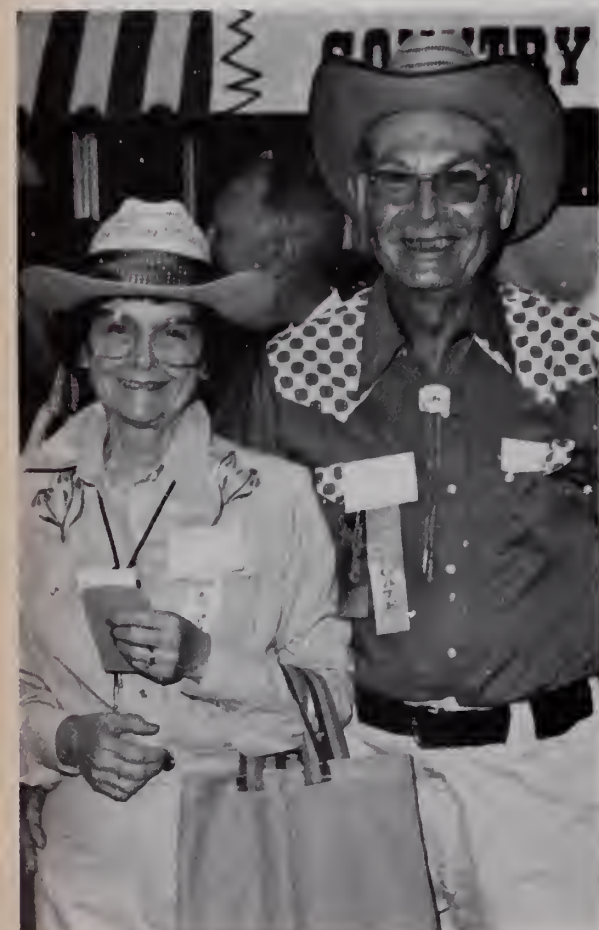
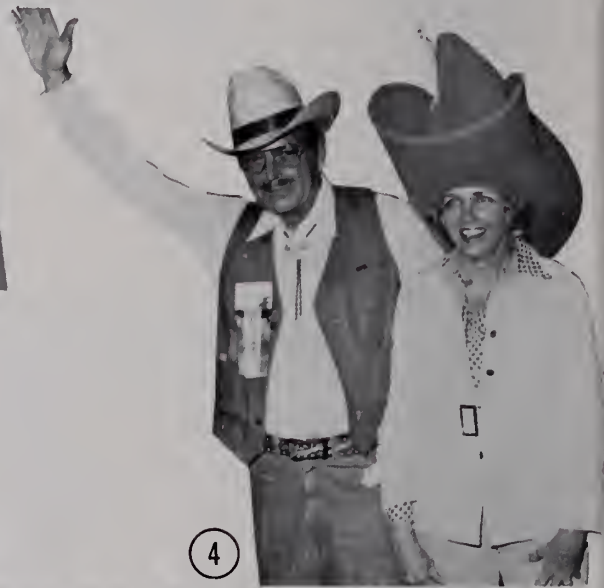


These Past Presidents of the Florida Medical Association obviously are in a convivial mood after enjoying their annual breakfast at the Annual Meeting. Front row (left to right): George S. Palmer, M.D., Tallahassee (1966); Jere W. Annis, M.D., Lakeland (1958); Jack Q. Cleveland, M.D., Coral Gables (1968); Walter C. Jones, M.D., Miami (1941); Samuel M. Day, Jacksonville (1964); and H. Phillip Hampton, M.D., Tampa (1965). Standing: Floyd K. Hurt, M.D., Jacksonville (1971);

Joseph C. Von Thron, M.D., Cocoa Beach (1973); W. Dean Steward, M.D., Marianna (1967); Thad Moseley, M.D., Jacksonville (1974); O. William Davenport, M.D., Miami (1978); Vernon B. Astler, M.D., Boynton Beach (1975); Jack A. MacCris, M.D., St. Petersburg (1976); Louis C. Murray, M.D., Orlando (1977); Henry J. Babers, M.D., Gainesville (1969); William J. Dean, M.D., St. Petersburg (1972); and James T. Cook, M.D., Marianna (1970).



FMA Does Country





5



8

Cowboy boots, five-gallon hats, flannel shirts and blue jeans were the conventional attire and hot dogs and barbecued beans were among items on the bill of fare for the President's Country and Western Cookout on Friday evening of the Annual Meeting. The beaming hosts, FMA President and Mrs. T. Byron Thames, M.D., appear in Photo #1. In Photo #2, Francis C. Coleman, M.D., who spends much of his life in his pathology lab, and Mrs. Coleman, seem to enjoy the change of scenery. President-Elect and Mrs. Sanford A. Mullen, M.D., greet guests in Photo #3. After a hard day's drive on the Chisolm Trail, cowpoke O. William Davenport, M.D., arrives at the spread with his lovely lady (Photo #4). Blue Cross and Blue Shield President William E. Flaherty listens patiently as FMA Secretary Robert E. Windom, M.D., spins a Texas-size yarn (Photo #5). Past President and Mrs. Joseph C. Von Thron, M.D. (right in Photo #6) do a quick scene with the hosts. Samuel M. Day, M.D., king of the fast draw, intimidates *The Journal's* photographer (Photo #7). Dr. and Mrs. B. David Epstein, M.D., say "howdy" as they arrive at the ranch (Photo #8).

6



7

Report of Reference Committee No. III

Finance and Administration

Dr. Thomas D. Bartley, Chairman, and his Committee came forward to present the report of the Reference Committee No. III — Finance and Administration.

Dr. Bartley expressed his Committee's wishes that Dr. Perry be commended for the clear and precise rules under which the House of Delegates acts and for Dr. Perry's summary given at the beginning of the meeting.

The Remarks of the Speaker presented at the First House of Delegates were adopted as presented. (See page 514 — First House of Delegates).

Dr. Bartley expressed his Committee's wishes to commend Dr. Thames for his aggressive leadership on behalf of the members of the Association for the past year.

The President's Address presented at the First Meeting of the House was filed. (See "President's Address", page 509).

Report A of the Board of Governors

The Reference Committee considered Report A of the Board of Governors, commended the Board for its outstanding performance during the year, and suggested particular action on the recommendations as follows:

While reviewing the portion of the Board's report dealing with Finances, the Committee was presented for its review CPA Audits for the Associations for which the FMA Officers are responsible: Florida Medical Association, Inc.; Florida Medical Foundation, Inc.; Florida Physicians' Insurance Reciprocal; Professional Insurance Management Company; Florida Medical Political Action Committee; Florida Physicians Association and Flamedco, Inc. The Committee found the audits acceptable.

James W. Walker, M.D., was approved as recipient of the 1981 Certificate of Merit as nominated by the Board of Governors.

Laurie L. Dozier, M.D., and Theodore John Kaminski, M.D., were approved as recipients of 1981 Certificates of Appreciation as nominated by the Board of Governors.

The Board's Recommendation A-1 was adopted.

The Reference Committee moved an amendment to Recommendation A-2 by deleting the phrase "which should place the Association in a financially stable position for the foreseeable future."

The amendment carried, and Recommendation A-2 was adopted as amended.

The Reference Committee moved an amendment to Recommendation A-3 by deleting the statement "That the Committee on CME be advised that this action does not forego the future possibility of a centralized system for administering the CME program".

The amendment carried, and Recommendation A-3 was adopted as amended.

The Reference Committee noted that the Board of Governors recommendation on Resolution 80-2 — Museum for Medical History, was numbered out of sequence as 80-4, and should be corrected by assigning Recommendation No. A-7.

The corrected Recommendation A-7 was adopted.

The Reference Committee moved an amendment to Recommendation A-5 by deleting in item #2 the phrase "the establishment of PRO's (PMUR) as a", and by substituting the word "alternatives" for the word "alternative", so that item 2 of the Recommendation reads: "The elimination of Professional Standard Review Organizations with support for suitable alternatives for PSRO's."

A motion was made from the floor to amend the Reference Committee's amendment by inserting the words "M.D.-controlled" after the word "suitable" so that the item would read: "The elimination of Professional Standard Review Organizations with support for suitable M.D.-controlled alternatives for PSRO's." The amendment carried.

The Reference Committee moved a further amendment by deleting item 4 and substituting therefor: "4. Discontinuance of the practice of the National Health Service Corps of placing National Health Service physicians in positions in which they are in competition with private practitioners of medicine," The amendment carried.

Recommendation A-5 was adopted as amended.

Recommendation A-6 was adopted.

There was a motion from the floor to reconsider Recommendation A-1. The motion to reconsider carried.

SECOND HOUSE OF DELEGATES



As usual, Reference Committee III (Finance and Administration) had the most business referred to it. Left to right: Rufus K. Broadaway, M.D., Miami, AMA Delegate Advisor; Fred S. Carter, M.D., Jensen Beach; Charles F. McConnell, M.D.,

Pensacola; Thomas D. Bartley, M.D., Gainesville, Chairman; Ms. Bonnie Todd, Recorder; Thomas R. Busard, M.D., Bradenton; and Margaret C.S. Skinner, M.D., Miami.

Recommendation A-1, which calls for a dues increase, was reconsidered and, by majority voice vote, was adopted.

Report A of the Board of Governors was adopted as amended.

Report A of the Board of Governors T. Byron Thames, M.D., Chairman

Your Chairman is pleased to submit this report to the House of Delegates regarding the activities of your Board of Governors during the past year, and also those activities of the Association's Councils and Committees.

Your Board and the many physicians who have given freely of their time on behalf of the Association, have exercised every effort to insure the highest level of medical care for the citizens of Florida and the preservation of the free enterprise system of health care delivery.

This report reflects the high level and broad scope of programs and activities in which the Association is currently involved, both as a result of pursuit of the goals and priorities of this Association, as well as the many crucial issues which continue to emerge and which affect physicians individually and collectively.

The report places particular emphasis on the present and future stability of the Association's finances, management and scope of activities, and the steps that have been taken to implement the actions taken by the House in May 1980, regarding these areas.

Your Chairman is grateful for having had the opportunity of serving this fine organization during the past year and it has been a particular pleasure to work with the high caliber of physicians who have served on the Board. Each of them has represented their fellow physicians unselfishly and to the best of their ability, and with the best interest of their colleagues always uppermost in their minds:

Sanford A. Mullen, M.D., President Elect
Gerold L. Schiebler, M.D., Vice President

Robert E. Windom, M.D., Secretary
J. Russell Forlaw, M.D., Treasurer
O. William Davenport, M.D., Past President — 1981
Richard S. Hodes, M.D., Imm. Past President — 1982
James F. Richards Jr., M.D., At Large — 1981
J. Lee Dockery, M.D., District A — 1982
Thomas E. McKell, M.D., District B — 1983
James G. White, M.D., District C — 1981
Norman M. Kenyon, M.D., District D — 1984
Joseph C. Von Thron, M.D., AMA Delegate — 1981
James B. Perry, M.D., Speaker of the House
Vernon B. Astler, M.D., FPIR — 1981
Eugene G. Peek Jr., M.D., HRS — 1981
Benjamin M. Cole, M.D., SBME — 1981

To my successor, Dr. Sanford Mullen, I extend my best wishes for the same rewarding experience that I have enjoyed in serving the FMA and I pledge to Dr. Mullen my fullest support in facing the crucial issues that affect all physicians.

Major Activities

1981 Annual Meeting — The Board approved the format for the 1981 Annual Meeting with Stress and Lifestyle as its theme. Dr. Henry Yonge and Dr. Calvin Martin, Chairman of the Scientific Program Subcommittee were commended for the continuing excellence of the scientific program and noted that physicians would be able to earn up to 20 hours of mandatory CME credit.

FMA Leadership Conference — More than 200 officers and others from county medical societies representing 96% of the FMA membership, took part in the Leadership Conference held January 31-February 1 at Lake Buena Vista. The purpose of the annual conference is to bring county society leadership up-to-date on FMA activities.

Governor Bob Graham headlined the conference as keynote luncheon speaker. In his remarks, the Governor expressed support for the separate office establishment for Medicaid and indicated that he was pleased with the Recovery of Costs Bill for medical malpractice cases which passed the Legislature in 1980 and with the decentralized institutional medical care now being provided. The Governor com-



Whoever was addressing the House of Delegates when this picture was made seems to have the complete attention of these delegates.

mended FMA for continuing to promote public health programs and expressed his hope that communications between himself and organized medicine would continue to be both open and candid.

The two-day conference covered a broad range of issues including:

- A status report on FMA priorities for 1980/81
- A review of the scope of activities for Councils and Committees
- A review of the finance and management of the Association
- A report on the Florida Physicians' Insurance Reciprocal
- A summary of AMA activities
- Medical School Deans' reports
- FMA Public Relations activities
- Legislative and FLAMPAC presentations
- An impaired physicians workshop
- A presentation by HRS Secretary, Alvin Taylor
- A report on the Department of Professional Regulations

A summary of the conference proceedings and presentations was included in the March issue of *The FMA Journal*.

The Florida Physicians' Insurance Reciprocal — An annual report of finances and other pertinent information on the FPIR for the year ending December 31, 1980, was mailed to the entire FMA membership in March and will be included in the Delegates Packet. This report reflects the current financial status of the FPIR, levels of coverage, claims activity, investment information and other corporate information. The following is a summary of the highlights of the report:

Board of Directors and Officers

The Board is composed of five subscriber physician advisors serving on a staggered-term basis. They select their successors or additions subject to approval of the Board of Governors of the Florida Medical Association, Inc. The current members are:

Vernon B. Astler, M.D.
Chairman, Delray Beach, 1986
(Past President, FMA)

Richard S. Hodes, M.D.
Treasurer, Tampa, 1984
(Past President, FMA)

Jack A. MaCris, M.D.
Vice Chairman, St. Petersburg, 1985
(Past President, FMA)

T. Byron Thames, M.D.
Orlando, 1982
(President, FMA)

O. William Davenport, M.D.
Secretary, Miami, 1983
(Past President, FMA)

W. Harold Parham, D.H.A., EVP of FMA, serves as Attorney-in-Fact and President.

Physician Participation — The Reciprocal has continued to grow, and at the end of 1980 there were 6,728 physicians insured out of a potential total market in Florida of approximately 10,000 physicians (Doctors of Medicine).

Policy Coverage — The Reciprocal offers three optional levels of liability coverage: \$500,000; \$1,000,000; and \$1,500,000. There is no aggregate, and the form is modified claims-made, participating, with a pre-paid endorsement for death, disability and normal retirement.

Professional association policies and premiums were discontinued for the 1980 policy year. This will prevent the plaintiff from pyramiding limits and reduce the premium by 20% for those insured physicians in partnership or multi-member professional associations.

Additional \$1 Million Layer — The Trust originally offered a \$500,000-limit policy, hoping to obtain another half million dollar layer which did not become available until December 1977. The physician now has the choice of coverage as explained above. These extra layers were obtained because of the favorable results and reputation which the Reciprocal has established.

The Reciprocal is the only physician-owned, medical society-sponsored, physician-managed insurance company providing professional liability insurance coverage in Florida and is one of a dozen such plans in America that are able to obtain reinsurance from the London market.

Underwriting — The Reciprocal contracts with the Florida Medical Association, Inc., and its component county medical societies to review and advise regarding physicians meeting underwriting standards of the Reciprocal.

Trends — Since the formation of the Trust in December 1975, a serious trend has been experienced. The number of claims has tripled and the severity has doubled, which has prevented the payment of additional dividends for 1980 and resulted in the first premium increase for 1981.

The FPIR will pursue the following priorities in future years:

1. An intensive obligatory malpractice prevention program in cooperation with the Florida Medical Association's county medical societies, specialty groups, annual meetings, and Florida hospital staff meetings;
2. A more aggressive investment policy (the Reciprocal's limited investments in real estate have been most rewarding);
3. Increased emphasis placed upon the claims handling, particularly of small claims, in an effort for them to be disposed of more expeditiously and efficiently;
4. A greater emphasis placed upon legal aggressiveness in defense of all nonmeritorious suits with regional coordination of legal counsel; and
5. A three-year plan of reinsurance in an effort to further stabilize the Reciprocal.

The loss of the mediation panels in Florida due to the Florida Supreme Court ruling in February 1980, has hopefully been offset by passage of the FMA supported Recovery of Costs Bill in malpractice suits during the 1980 Session of the Florida Legislature.

In addition to the annual report of the Reciprocal, which has been sent to all FMA members, any physician subscriber may review the CPA audit by appointment with the Reciprocal comptroller in the Jacksonville office. The conventional financial statement is on record with the State Insurance Commissioner and may be reviewed in his office in Tallahassee or at the Reciprocal office.

1980 House of Delegates Actions and Referrals

The 1980 Proceedings of the House of Delegates were reviewed and items requiring additional study and action were referred to the appropriate Councils and Committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various Council and Committee reports as well as in this and other reports of the Board.

Finances — The House of Delegates, at its meeting in May 1980, authorized the Board of Governors to rigidly limit and curtail the scope of activities of the Association, its councils and committees within the organization's stated objectives in order to insure fiscal integrity through 1980-1981. Special emphasis should be given to those activities which directly affect the membership of the Association.

Following the guidelines set by the House, the Board approved:

- Restructuring of FMA councils and committees to provide for more efficient and coordinated activities to best represent the needs and interests of the FMA membership.
- FMA Council Chairmen for 1980-1981 include:
 Council on Legislation, Louis C. Murray, M.D., Chm., Orlando.
 Council on Health Care Financing, William W. Thompson, M.D., Fort Walton Beach.
 Council on Medical Services, Joseph T. Ostroski, M.D., Chm., Miami.
 Council on Scientific Activities, Yank D. Coble Jr., M.D., Chm., Jacksonville.
 Council on Specialty Medicine, Dick L. Van Eldik, M.D., Chm., Lake Worth.
 Judicial Council, James A. Winslow Jr., M.D., Chm., Tampa
- Authorized continued staff and administrative support for the Florida Medical Foundation, FLAMPAC, Florida Physicians Association and the FMA Auxiliary.
- Approved continued support for Solution Systems, Inc., and the Florida Health Data Corporation.
- Directed management to exert every effort to eliminate all administrative activities not directly needed for support of the current priorities and programs of the Association.

The House directed that the Board of Governors implement such a reorganization plan as necessary to accomplish these objectives and report back to the House of Delegates in 1981 with definite recommendations regarding the financing of the Association for future years.

The House further directed that the Board of Governors annually present to the House of Delegates not only a complete report of the financial status of the Association, but a recommendation regarding the amount of dues necessary for the upcoming year in order to maintain the Association's financial stability and integrity.

The House of Delegates also authorized the Board to establish a special Trust Fund for the current and future reserves of the Association, the initial funding coming from the approximately \$600,000 profit from the sale of the headquarters building in Jacksonville. The Trustees of this fund might be the last five living past-presidents and perhaps consideration should be given to the addition of one or two lay financial advisors. The Trustees would release income and other funds to the Association only when it became absolutely necessary for a matter of great importance to the Florida Medical Association and upon request of the Board of Governors. The use of such funds should be contemplated only when an emergency existed that could not be financed through the regular income and assets of the Association.

Pursuant to the actions of the House in 1980, the Board appointed two special ad hoc committees on Finance and Management to study in depth the financial and management structure of the Association and to develop recommendations to implement the actions of the House of Delegates last May.

The Ad Hoc Committee on Finance is composed of FMA Treasurer, Dr. Russell Forlaw, Chairman; Dr. Robert E. Windom, Secretary and Dr. T. Byron Thames, FMA President.

The Committee reviewed in detail the Association's financial position, including income and expenditures for the year ending December 31, 1980. The Committee also discussed the pros and cons of an FMA dues increase and the feasibility of incremental increases each year or a larger amount less frequently.

The Committee observed the findings of the Special Committee on Finance and its recommendations to the House of Delegates in 1980 relative to the scope of FMA activities and noted that this has been largely accomplished through reorganization of the FMA's Council and Committee structure and activities.

The Committee also reviewed the actions of the House and subsequently the Board of Governors, regarding the establishment of a special Trust Fund for current and other reserves of the Association.

The Association had an income during 1980 from all sources of \$2,954,356 and total expenditures during the year of \$2,295,429 for a gross gain of \$658,927. It is important to observe that:

- The combination of the profit on the proceeds of the sale of the 801 Riverside Avenue property with the high yields on FMA funds placed in Certificates of Deposit and the money market had generated well over \$100,000 in additional revenue for the year. Also, the purchase of 760 Riverside Avenue for \$455,000 was carried as a transfer of assets rather than an expenditure.
- The net proceeds from the sale of the 801 Riverside Avenue and the purchase of 760 Riverside Avenue left a net of \$137,000 and, as directed by the Board, this was placed in the FMA Reserve Trust Account at Southeast Bank Trust Company N/A, which is not considered to be available for current operations.
- The gross gain in income (\$658,927); less the one-time profit from the building sale \$597,313 left the Association with a net gain of \$61,614 or less than 1%. The Association's liquid reserves have been basically eliminated with the FMA taking back a \$1 million mortgage note from Barnett Bank Trust Company at 801 Riverside Avenue (i.e., it was necessary for the FMA to pay off a Commercial Union

mortgage on 801 Riverside of approximately \$600,000 to transfer clear title)

- The figures do not reflect expenditures for equipment or depreciable items as they are a transfer from liquid to fixed assets.
- In 1976, the Association implemented a special assessment to be restricted for the purpose of public relations and legislative activities. Interest of \$21,097 was earned on these funds in 1980 and \$62,858 was expended for public relations in 1980. The balance of the special assessment funds as of December 31, 1980 was \$172,094.
- The total assets of the Association as of December 31, 1980 were \$2,941,063 less liabilities of \$74,515 for net assets of \$2,866,548 (including \$309,094 restricted for the special assessment and Reserve Fund).

The audit conducted by the Association's CPA firm of Harbeson, Beckerleg and Fletcher for the year ending December 31, 1980, is available for inspection by any member of the Association who may desire to review it.

1981 Budget — The Board reviewed the FMA financial statement and proposed 1981 Budget presented by the Treasurer and the EVP which had been reviewed and approved by the Ad Hoc Committee on Finance. It was noted that anticipated income for 1981 would only be 1% higher than the previous year. The Board approved the proposed budget for 1981 with a total anticipated income and expenditures in the amount of \$2,135,000.

Following the guidelines established by the House of Delegates last May, the Board approved:

- Establishment of a special trust fund for current and future reserves of the Association, the initial funds to come from the profits on the sale of the building at 801 Riverside Avenue after purchasing the building located at 760 Riverside Avenue as provided for in the lease purchase option with the Florida Physicians' Insurance Reciprocal.
- That the Trustees of these funds be the three (3) immediate living past-presidents of the Association, excluding the immediate past-president who is an officer.
- That the principal and interest of these funds accrue in this trust account which shall be established in the name of the Association in an escrow trust. The Trustees may release the funds upon request of the Board of Governors which indicates that an emergency exists which cannot be financed through regular income or assets of the Association. In the event the Trustees do not agree to release the funds, the Board of Governors may direct their release upon $\frac{3}{4}$ vote of the active members of the Board of Governors.
- That the Trustees of this fund shall elect their own Chairman and other officers as required.

The Reserve Trust Fund Committee is currently comprised of Dr. Jack MaCris, (most senior) Chairman; Dr. Louis Murray, (2nd most senior) Secretary; and Dr. O. William Davenport, (3rd most senior) Treasurer. The Board has approved that this selection of officers be continued in future years for an orderly transition when a member's term expires each year and a new past president becomes a member.

The Committee has met and, as indicated above, has made an initial deposit in the Reserve Trust Fund in the amount of \$137,000.

Based on the recommendations of the Committee, the Board of Governors has approved

- The selection of the Southeast Bank Trust Company as the Trustee for the FMA Reserve Fund as established by the Executive Vice President.
- The continued use of the money fund of the Southeast Bank Trust Company until the next meeting of the Committee which shall be held during the Annual Meeting of the FMA unless the EVP recom-

mends a change prior to this time.

- The designation of the FMA EVP as the Agent for this Committee to conduct any necessary transactions on behalf of the Committee.

In considering further deposits to be made to this account the Board expressed the hope that some capital returns to the Association (i.e. principal on mortgages) might be deposited to the account with the goal that when additional funds were in this account it would add greater stability to the Association and not necessitate assessments and so forth when future crises arise.

RECOMMENDATION NO. A-1

THAT BASED UPON THE RECOMMENDATION OF THE SPECIAL COMMITTEE ON FINANCE AND PREVIOUS ACTIONS OF THE BOARD OF GOVERNORS, HOUSE OF DELEGATES AND THE EXECUTIVE STAFF IN STREAMLINING AND GREATLY INCREASING EFFICIENCY OF THE ASSOCIATION AND THE ACUTE INFLATIONARY FACTOR IN OUR ECONOMY AFFECTING EVERYONE, THE HOUSE OF DELEGATES APPROVE AN INCREASE IN THE DUES OF THE FLORIDA MEDICAL ASSOCIATION IN THE AMOUNT OF \$50.00 (\$175.00 TO \$225.00), EFFECTIVE JANUARY 1, 1982, WITH DUES TO REMAIN UNCHANGED FOR OTHER MEMBERSHIP CLASSIFICATIONS (\$50.00 FOR ASSOCIATE MEMBERS, AND \$10.00 FOR MEDICAL STUDENTS, INTERNS AND RESIDENTS); AND, THAT THE BOARD OF GOVERNORS RECOMMEND TO THE HOUSE OF DELEGATES ANNUALLY WHETHER AN INCREASE OF DUES IS NECESSARY TO CARRY OUT THE PROPER FUNCTIONS OF THE ASSOCIATION.

RECOMMENDATION A-2

THAT THE INTEREST INCOME FROM THE ASSOCIATION'S MORTGAGE PAYMENTS RECEIVED FROM THE ONE MILLION DOLLAR MORTGAGE ON THE PROPERTY IT SOLD AT 801 RIVERSIDE AVENUE BE UTILIZED FOR OPERATING EXPENSES, BUT THE PRINCIPAL PAYMENTS AVERAGING \$100,000.00 PER YEAR FOR TEN YEARS, BE KEPT IN A RESERVE (CAPITAL) ACCOUNT.

FMA Management — In concurrence with the EVP's request to be relieved of management responsibilities following the 1984 Annual Meeting, the Board appointed a special committee on management in May 1980 to study and make recommendations regarding the philosophy to be approached by the Association regarding the position of the EVP (Chief Administrative Officer) and the transition period. The Committee is composed of Vernon B. Astler, M.D., Past-President and Chairman; James B. Perry, M.D., Speaker of the House; and T. Byron Thames, M.D., President. The Committee in carrying out its responsibilities:

1. Reviewed the management contract with the Executive Vice President which expires April 1, 1985.
2. Concurred with the Executive Vice President's request to be relieved of management responsibility following the 1984 Annual Meeting.
3. Concurred with the other Board of Directors who have employed Dr. Parham and requested he continue as Attorney-in-Fact/President of the Florida Physicians' Insurance Reciprocal; and Chairman of the Board of PIMCO; following his retirement from the FMA.
4. The history of the FMA Management, i.e.
 - A. 1918-1923 — Part time officer



These three physicians were very visible during the Annual Meeting. Luis M. Perez, M.D., Sanford (left), gave the invocation at the opening session of the House of Delegates and was later elected Secretary of the Association. Speaker of the House James B. Perry, M.D., Fort Lauderdale (center), was the chief

presiding officer and was elected to a second term as Speaker. The House promoted Robert E. Windom, M.D., Sarasota (right), from Secretary to President-Elect during the annual election of officers.

- B. 1923-1926 — Part time Managing Director (Stewart Thompson, D.P.H.)
- C. 1926-1953 — Full time Managing Director (Stewart Thompson, D.P.H.)
- D. 1953-1958 — Full time Managing Director (Ernest R. Gibson)
- E. 1958-1968 — Full time Executive Director (W. Harold Parham, D.H.A., joined FMA 1949)
- F. 1968-1980 — Full time Executive Vice President (W. Harold Parham, D.H.A.)
- 1974-1980 — Full time Executive Director (Mr. Donald C. Jones)
- 5. Management studies which reflects a history of strong and efficient management and investment income unique to medical association activities.
- 6. The current activities and affiliate activities of the EVP authorized or requested by the Board of Governors.
- 7. Current senior executive personnel of FMA and affiliated organizations.
- 8. Current activities and programs of the FMA and affiliates.

The Board approved the recommendations of the committee in October 1980, that:

- 1. The FMA senior staff responsibilities be reorganized as follows:
 - A. Executive Vice President (W. Harold Parham, D.H.A.) shall continue as chief executive officer but begin transfer of his responsibilities so that they be confined to development and implementation of the policies and finances of the Association and related organizations; that he continue as secretary/treasurer of the Florida Medical Foundation; Chairman of the Board of PIMCO; Attorney-in-Fact/President of the Florida Physicians' Insurance Reciprocal; Chairman of the Board, Solution Systems; Chairman, FLAMEDCO, Inc.; Assistant Treasurer of FLAM-

PAC; hold the proxy for all FMA stock; and shall obtain adequate insurance bonding, CPA's, and legal counsel to protect the financial integrity of the FMA and its direct responsibilities.

- B. Executive Director (Donald C. Jones) shall be primarily responsible for the development, organization, coordination, and implementation of the overall activities and programs of the FMA and the Florida Medical Foundation. He shall be also responsible for the management of the Association's meetings, department of the Association's executive office, personnel, administration, communications, and accounting. He shall have direct staff responsibilities for the officers, Executive Committee, Board of Governors, the House of Delegates, and the AMA Delegates and maintain a current abstract and summary of all FMA policies. He shall have additional responsibilities as outlined in the *General Responsibilities and Duty Assignments* booklet as determined by the Executive Vice President.
- C. The Associate Executive Director and Legal Counsel (John E. Thrasher, Esq.) is responsible for and to supervise all:
 - 1. Legal activities and activities which have legal implications affecting the FMA and its membership.
 - 2. Public Affairs Programs which shall include all public relations, legislation, and political education activities of the Association.
- D. The remainder of the staff shall be organized in compliance with sound management principles and dictated by the Association policies and programs to be developed by the Executive Vice President and implemented by the Executive Director.
- 2. That the current EVP continue to transfer the majority of his FMA responsibilities to the Executive Director and Associate Executive Director until prior to his retirement from the FMA, he retains only financial and policy responsibilities and no operational responsibilities, and that the Executive Director be trained in these areas also.

3. That FMA take advantage of Dr. Parham's proven management and financial ability and that upon retirement, he be retained as a consultant for finance and policy to the Board of Governors through the Executive Committee for a minimum period of five years.
4. That the Management Committee be continued through the management transitional period, report to the Board at least annually regarding the progress, additional recommendations; and that the current President and President-elect of the FMA serve on the Committee during their term of office. The Board noted the progress to date in March 1981 with pleasure.

Impaired Physicians Program — The House approved the establishment of a statewide Impaired Physicians Program and referred this to the Board of Governors for implementation at such time as the Board is of the opinion that A) appropriate legal and statutory provisions exist to protect the confidentiality of records, and B) adequate funding is available for implementation and that progress on the development of this important program be reported by the Board to the House of Delegates at its next meeting.

The Board directed:

- That an impaired Physicians Program be established by the Florida Medical Foundation.
 1. That the program be phased in as funds and personnel become available.
 2. Subject to the legal clarification regarding confidentiality and liability.
- That the Committee on Impaired Physicians be nominated by the President of the FMA and approved by the Board of Governors of the FMA as a standing committee of the Florida Medical Foundation.
- That the FMA make an annual grant to the Foundation to be utilized for this program.
- The Board has authorized an FMA contribution of \$75,000 through the end of calendar year 1981 (includes \$25,000 grant for balance of 1980) for implementation of the program.
- That the FMF solicit the membership of the FMA and Auxiliary for donations and contributions to this fund.
- That the program be initiated with a part time consultant.
- That appropriate liability insurance be obtained.
- Reiterate that all employees and consultants must be approved by the Board of Directors of the Florida Medical Foundation.

The Board has studied the need for additional legislative guarantees for the confidentiality of records and deliberations of the Committee on Impaired Physicians. This has been carefully reviewed by FMA legal counsel and other interested parties and it was the Board's feeling that current law will allow impaired physicians to be involved in the Association's program without being formally brought under the "Tattle Tale" provisions of the law. The Board is greatly appreciative of the time and effort expended by the Committee on Impaired Physicians in developing the program and a complete report on the committee's activities is included in the delegates handbook.

House of Delegates Actions and Referrals

Drug Abuse Committee — The House of Delegates requested that consideration be given to the re-establishment of the Committee on Drug Abuse and that this be referred to the Board of Governors for consideration.

The Board directed that a Committee on Drug Abuse be re-established under the Council on Medical Services and this has been accomplished.

Continuing Medical Education Records — Resolutions No. 80-7 introduced by the Escambia County Medical Society, and 80-8 introduced by the Pinellas County Medical Society were not adopted but referred to the Board of Governors for further consideration.



Among those who attended sessions of the House of Delegates were top Auxiliary officers. From left: Mrs. B. David Epstein, Long Range Planning Committee member; Mrs. Harry S. Dvorsky, President of the AMA Auxiliary; Mrs. Linus Hewitt, AMA-A Treasurer; and Mrs. Frank Coleman, FMA Auxiliary President.

RESOLUTION NO. 80-7

RESOLVED, That the Resolution 77-19 on centralized computer continuing medical education records adopted by the House of Delegates at the Florida Medical Association Annual Meeting in 1977, be rescinded; and further be it

RESOLVED, That record keeping of continuing medical education with eventual transfer of records to the Florida Medical Association be continued at the local county medical society level because experience demonstrates its effectiveness.

RESOLUTION NO. 80-8

RESOLVED, That the accounting and reporting of continuing medical education credits not be centrally computerized, and be it further

RESOLVED, That continuing medical education accounting and reporting be left to the local societies.

The Board reviewed the history of the CME program including requirements, reporting methods, various policies of the Association, and the expenditure of funds and submits the following recommendations to the House.

RECOMMENDATION NO. A-3

THAT THE FOLLOWING CRITERIA AND PROCEDURES FOR THE FMA CME PROGRAM BE ADOPTED IN LIEU OF RESOLUTIONS 80-7 AND 80-8:

- THE PRIMARY RESPONSIBILITY FOR RECORDING, MAINTAINING AND APPROVING CME CREDITS REMAIN WITH THE INDIVIDUAL PHYSICIAN'S COUNTY MEDICAL SOCIETY.
- THAT THE COUNTY MEDICAL SOCIETIES REPORT TO THE FMA AT THE APPROPRIATE REPORTING TIME FOR ITS MEMBERS THAT THE INDIVIDUAL PHYSICIAN HAS COMPLIED WITH THE CME REQUIREMENTS OF THE FLORIDA MEDICAL ASSOCIATION. (THIS MAY BE DONE AT THE TIME OF THE TRANSMISSION OF THE PHYSICIAN'S FMA DUES)
- THE FMA BE UTILIZED PRIMARILY FOR MAT-

TERS OF APPEAL WHEN THERE IS A DISAGREEMENT BETWEEN THE PHYSICIAN AND THE COUNTY MEDICAL SOCIETY OR A CASE OF HARSHIP.

Resolution 80-14 — State Health Plan — The House of Delegates referred this resolution which was introduced by Charles F. Tate Jr., M.D., Delegate, to the Board of Governors for further consideration.

RESOLUTION NO. 80-14

RESOLVED, That each year the Florida Medical Association through its specialty societies and expertise will develop a state health plan of its own, for all agencies throughout the state to have immediately available for reference, study and planning purposes.

The Board referred Resolution 80-14, to the Committee on HSA's and the Council on Specialty Medicine for further study and consideration of the most effective manner for the FMA to evaluate the state health plan utilizing specialty groups and making possible alternate recommendations. The report of the Council on Health Care Financing reflects the activities relating to mechanisms for evaluation of the state health plan.

The Board also directed that the FMA seek the opportunity for providing input into the State Health Plan as it is being developed rather than after the fact.

Resolution 80-2 — Museum for Medical History — The resolve of this resolution which was introduced by the Duval County Medical Society, asked that FMA designate Old St. Lukes Hospital as a Museum for Medical History in Florida.

This resolution was not adopted but referred to the Board of Governors for further review, investigation and clarification of its intent.

The Board requested the Vice President to review Resolution 80-2 and report back to the Board of Governors with recommendations which were subsequently considered at the October meeting of the Board.

RECOMMENDATION A-7

THAT THE FMA ADOPT THE FOLLOWING POSITION WITH REGARD TO THE DESIGNATION OF AN HISTORICAL SITE OR MEDICAL MUSEUM:

THAT ANY COUNTY MEDICAL SOCIETY MAY NOMINATE AN HISTORICAL SITE OR MEDICAL MUSEUM WITHIN THEIR GEOGRAPHIC AREA. SUCH PROPOSALS WILL BE REVIEWED BY THE COUNCIL ON SCIENTIFIC ACTIVITIES AND ITS RECOMMENDATIONS REVIEWED BY THE BOARD OF GOVERNORS WHO SHALL MAKE THE FINAL DECISION.

THAT THE BOARD OF GOVERNORS BE AUTHORIZED TO DESIGN AND AWARD A PLAQUE DESIGNATING THE FACILITY OR SITE AS A HISTORICAL SITE OR A MUSEUM OF MEDICAL HISTORY, AND FURTHER

THAT FMA BY SUCH ACTIONS IN NO WAY OBLIGATES ITSELF TO ANY FISCAL INVOLVEMENT TOWARD THE DESIGNATION, MAINTENANCE OR RENOVATION OF SUCH SITES, MUSEUMS OR FACILITIES.

Resolution 80-9 — Medicare — Physicians Fees — This resolution, introduced by the Pinellas County Medical Society, resolved that the Board of Governors of the Florida Medical Association use whatever means necessary to induce Medicare carriers in Florida to

cease telling Medicare recipients that a physician's charge or fee has been reduced and that the FMA work with the carriers to improve the language of communication to Medicare recipients.

The Board requested the President to send a letter to Blue Cross/Blue Shield, G.H.I., and all appropriate government agencies reiterating the position of the FMA regarding this subject.

A letter was subsequently received from Blue Cross outlining actions taken to resolve this problem including changing or deleting the use of the words "charge or charges" when referring to allowances and also requesting Medicare Part B to review all nonroutine correspondence to providers and beneficiaries.

Resolution 80-10 — Osteopathy — This resolution, introduced by the Broward County Medical Association, resolved that the FMA Bylaws, Chapter 1, Section 1.2 be amended as follows:

"Any doctor of osteopathy who has satisfactorily completed an AMA approved internship and/or residency training program or who has been certified by a specialty board recognized by the American Board of Medical Specialists may be accepted into membership in the Florida Medical Association, Inc., upon certification . . ."

The resolution was not adopted but referred to the Board for further review, investigation and clarification of its intent.

The Board requested the Speaker of the House to consult with the Broward County Medical Association to clarify the purpose of the resolution.

The Broward County Medical Association subsequently expressed its desire to withdraw the resolution.

RECOMMENDATION NO. A-4

THAT NO FURTHER CONSIDERATION BE GIVEN TO ADOPTION OF RESOLUTION 80-10, OSTEOPATHY.

Appointments

The Board of Governors approved the nomination of Joseph C. Von Thron, M.D., as the AMA Delegate to serve on the Board of Governors. J. Lee Dockery, M.D., was appointed as optional member of the Executive Committee.

Appointed as advisory members of the Board of Governors were Vernon B. Astler, M.D., Florida Physicians' Insurance Reciprocal and Public Relations Officer; Eugene G. Peek Jr., M.D., Department of HRS; and Benjamin M. Cole, M.D., State Board of Medical Examiners.

Daniel B. Nunn, M.D., served as Editor of *The Journal of the Florida Medical Association* for 1980-81 and was reappointed for 1981-82. William M. Straight, M.D., was appointed FMA Historian and Historical Editor of *The Journal*. J. Lee Dockery, M.D., was appointed as an Assistant Editor to *The FMA Journal* from the Board of Governors.

Appointed as Chairman of the Board of Governor's Ad Hoc Committee on Finance was J. Russell Forlaw, M.D., T. Byron Thames, M.D., and Robert E. Windom, M.D., also were appointed to serve on this Committee. Vernon B. Astler, M.D., was appointed as Chairman of the Board of Governor's Ad Hoc Committee on Management. Also appointed to serve on this Committee were T. Byron Thames, M.D., and James B. Perry, M.D.

Edward R. Annis, M.D., was appointed Chairman of the FMA Speakers Bureau.

James T. Cook Jr., M.D., and Joseph C. Von Thron, M.D., were elected as Chairman and Vice Chairman respectively of Florida's AMA Delegates.

Awards

A. H. Robins Award — The Board reviewed nominations received from county medical societies and selected the recipient of the A. H. Robins Award "For Outstanding Community Service by a Physician." This award will be presented at the First Meeting of the

House of Delegates on April 29, 1981. The recipient for this year's award will be included in the Delegates' Packets.

Distinguished Layman Award — The Board has selected the 1981 recipient of the Distinguished Layman Award. The appropriate citation, along with the criteria will be included in the Delegates' Packets.

Nominations

Certificate of Merit — The Board selected an outstanding physician for nomination to the House of Delegates to receive the Certificate of Merit for 1981 (the Association's highest honor of achievement). This nomination will be included in the Delegates' Packets for approval by the House of Delegates.

Certificate of Appreciation — The Board selected 2 physicians to be nominated to the House of Delegates as recipients of the 1981 Certificate of Appreciation. These nominations will be included in the Delegates' Packets for approval by the House of Delegates.

Judicial Council — In compliance with the FMA Bylaws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1981. The Board wishes to nominate Dr. Maurice Laszlo for election to the Judicial Council as the At-Large representative for a five-year term to replace Dr. Vincent P. Corso who has served on the Judicial Council for two consecutive five-year terms and is not eligible for reelection.

Committee on Membership and Discipline — The Board will submit nominations to the House for election to the Committee on Membership and Discipline in a supplemental report.

Board Actions of Major Importance

FMA Priorities 1980-81 — The Board adopted the following Association Priorities for 1980-81 and directed that the Association staff and resources be utilized to carry out these Priorities.

Membership:

Communication with FMA membership directly and through respective county medical and specialty societies.

Implementation of a statewide impaired physicians program to be phased in as funds and personnel become available. (Through the Florida Medical Foundation)

Public:

Continue to provide government bodies and the public through public relations programs and Speakers Bureau, press releases, etc., with prompt and responsive Association views on:

- A. Matters relating to public health, mechanisms and standards of health care services and delivery including HSAs, HMOs, etc.
- B. Cost of medical care with special emphasis on what organized medicine is doing to stabilize and reduce cost and on the role government plays in escalating costs.

Program :

- A. Restructure of FMA Council and Committees and scope of activities to best serve the interest of the membership.
- B. Continued implementation of FMA medical services programs with special emphasis on drug abuse, emergency medical services and school health.
- C. Continued emphasis on local support for legislative activities and development of active political education programs in cooperation with the FMA Auxiliary in each community.
- D. Educational programs and activities on stress with special emphasis on lifestyle.
- E. Continued emphasis on a statewide PMUR program, conducted

by the private sector, as a viable alternative to a Federal Government controlled program whose emphasis is solely on cost without regard to quality.

- F. Continue support for development and marketing of a Medical Encounter Data System (Solution Systems) for physicians and the Florida Health Data Corporation.
- G. Continued support of the FMA Auxiliary's educational programs in the community.

Issues:

- A. Cost of Medical Care
- B. Continued monitoring of the effectiveness of the Department of HRS as it pertains to the public's health and continued strong support for ensuring effective medical physician leadership at all levels of the Department.
- C. Opposition to any compulsory comprehensive national health insurance program.
- D. Health regulatory activities involving interference in practice of medicine.
- E. Professional liability
- F. Strongly support the availability of quality health care for all people. Strongly oppose government subsidized programs, agencies and systems that are costly, restrictive and unfairly interfere with the private practice of medicine and with the quality and availability of health care.
- G. Opposition to encroachment on the practice of medicine by non-M.D. health care providers.

Membership:

The FMA has continued its efforts during the past Association year to intensify and improve communications with its component county medical societies, FMA membership At-Large, recognized specialty groups and other related organizations. You will find this reflected throughout the Delegates' Handbook and the Annual Reports of the Public Relations Officer, the FMA Speakers Bureau and many of the FMA's Councils and Committees and also numerous activities of the Board which are being reported on.

FMA field office liaison, the annual FMA Leadership Conference, the FMA visitation program with county medical societies and specialty groups and the rotation of FMA Board Meetings throughout the State to allow for more participation by medical societies in Board Meetings are examples of the Association's continuing efforts to bring the FMA closer to the membership. Significant action taken by the Board in this regard was to direct that county medical societies be advised approximately 30 days in advance of each Board Meeting of the general items of business to be included on the agenda and that the county medical society president, or his designated physician representative, be invited to attend to discuss those items that they may be interested in. The Board reaffirmed the policy of rotating meetings of the Board to different areas of the State and that invitations to attend be extended to the presidents of surrounding county medical societies and their executives if they desire. The Board also directed that policy be reinstated of inviting county medical society executives to attend the FMA Executive Staff Meeting held immediately following Board Meetings to be advised of actions taken by the Board.

FMA has attempted to carry out in-depth communications with membership through various Association publications and newsletters, including *The FMA Journal*, the Board Summary which has been reprinted in *The Journal* to apprise the membership of the major actions taken by the Board, the President's Memo, which has been utilized for relating single issues of prominent concern or interest, the FMA Briefs which has included a broad range of topics relating to medicine, and the FMA Gray Paper which is primarily disseminated to county medical societies for their information and appropriate action and distribution regarding issues of timely importance.

The House of Delegates at its meeting in May of 1980 approved the establishment of a Statewide Impaired Physicians Program and charged the Board of Governors with its implementation. An in-depth report regarding the program is included in another section of the Board's report to the House and also in a comprehensive report from the Foundation's Committee on Impaired Physicians.

Public:

Reflected throughout the entire Delegates' Handbook are examples of the Association's efforts to provide prompt and responsive views on all aspects of health care issues, programs and delivery mechanisms at the national, state and local level. Significant policies have been established, particularly in the areas of public health, standards of health care, health care delivery mechanisms, cost and quality, for which recommendations are being submitted for deliberation by the House.

Programs:

Throughout the past Association year, major emphasis has been placed on in-depth study of the Association's scope of activities and financial stability. This important activity is a result of several important factors including the incessant growth in crucial issues facing organized medicine, the spiraling inflation and the increasing demands on Association resources and staff to carry out the many diversified activities.

The House of Delegates, at its meeting in May of 1981, received a report from a special Committee of the Board of Finance chaired by Dr. Jere W. Annis, the thrust of which was to point up the need for a greater evaluation of the future scope of activities and expenditures of the FMA. The House responded to the report by authorizing the Board of Governors to rigidly limit the scope of activities to those which directly affect the membership and directed the Board to implement such a reorganization plan and to report back to the House with definite recommendations regarding the Association's future financial needs. An in-depth report and recommendations is included in the Board's report to the House of Delegates.

The annual report of the Council on Medical Services reflects that emergency medical services remains a high priority issue among the many medical service programs of the FMA. Despite the significant progress that has been achieved during the past decade in the field of emergency care, the FMA is of the opinion that there is a definite need for more medical direction in the State's EMS program and for the Department of HRS to significantly increase its EMS planning activities and that providers play a key role in such planning. Presently, the major concern of the FMA's Committee on EMS is that the State EMS office is overburdened with the regulatory activities involving ambulance licensure and certification of emergency medical technicians and paramedics. As a result, there is an inadequate medical direction and lack of planning activities, both of which are crucial in the rapidly changing field of emergency medicine. Florida was once considered a leader in the nation for the development of EMS programs. However, it no longer enjoys such recognition. The FMA is confident that with proper planning and close cooperation with the Department of HRS, Florida can regain its leadership role. The FMA, through the Florida Medical Foundation, is actively pursuing an agreement with the Department of HRS for the express purpose of contracting for:

1. A medical director for all DHRS EMS programs to assure quality medical input and coordination.
2. Planning and development of state EMS programs involving:
 - a. Trauma and other critical care categories
 - b. Transfer systems and agreements
 - c. The development of a statewide data retrieval system to determine hospital capabilities for handling critical care patients
 - d. Pre-hospital emergency medical services.



Three women important in the life of FMA President T. Byron Thames, M.D., attended the FMA Annual Meeting. Left to right: Mrs. Thames, a Past-President of the FMA Auxiliary; Ms. Marie Waller, Dr. Thames' office manager who retired earlier this year; Ms. Madeline Lange, R.N., his office nurse; and Dr. Thames.

The activities in the areas of drug abuse and school health are reflected in the Council on Medical Services report and passage of legislation for funding for school health services is among FMA's legislative priorities.

FMA President, Dr. Thames, selected stress and lifestyle as the scientific theme during his tenure as President. This theme has been carried out in the Scientific Program for the 1981 FMA Annual Meeting and through the April issue of *The FMA Journal* which is devoted to this theme. The contributions of the FMA Auxiliary to the programs and activities of the Association and on behalf of the Florida Medical Foundation have been invaluable. The Auxiliary has made significant contributions to the FMA's efforts in the areas of legislation, political education, public relations and in the development and implementation of the Impaired Physicians Program. In recognition of their many contributions and to assist in enhancing the overall activities of the Auxiliary, the Board of Governors has authorized the hiring of an FMA executive employee to be assigned to the Auxiliary for coordinating on a statewide basis activities in the areas of Legislation, Public Relations, Political Education and other activities as appropriate.

The FMA continues to advocate a position of strong opposition to any form of compulsory national health insurance and is exploring in any possible manner the implementation of peer medical utilization review programs, conducted by the private sector, as an alternative to federal government controlled programs whose primary interest is on cost, rather than quality. The Board of Governors report will reflect actions which have been taken in support of the elimination of funding for PSRO's and also repeal of Public Law 93-641, the Health Planning and Development Act.

The FMA, through the Florida Medical Foundation, has continued its efforts to develop and market a medical encounter data system (Solution Systems) for physicians. A cooperative agreement has now been finalized with Penn Mutual Life Insurance Company and Control-O-Facts, to market the system with research and development to be carried out by the Florida Medical Foundation. Stability of the professional liability market in Florida continues to be an issue of major concern to the Association and the Florida Physicians' Insurance Reciprocal which was established as a result of the medical malpractice crisis

that occurred during 1975. The FMA is continuing efforts to explore every feasible, legal and legislative remedy to this continuing problem. Dr. Vernon Astler, Chairman of the FPIR will present a report on the current status of the Reciprocal to the House of Delegates.

Litigation and Investigations — The Board received a report regarding the status of litigation and investigations the Association has been involved in during the past year.

1. Florida Medical Association, et al v. HEW

The latter part of October 1979 Judge Charles O. Scott granted FMA's Petition for Permanent Injunction which enjoined HEW from releasing the names of physicians and an appeal of this decision to the Fifth Circuit Court of Appeals and subsequently dropped that appeal, thus allowing Judge Scott's decision to stand as rendered.

This action, on behalf of the members of the Florida Medical Association, and the American Medical Association enjoins the Department of HEW from disclosing any lists of annual Medicare reimbursements, for any years, which would personally and individually identify those providers of services under the Medicare program. The Court's Order further provides that any such disclosure of annual Medicare reimbursement amounts, for any years, in a manner that would personally and individually identify the providers of services under the Medicare program is declared to be contrary to Federal Law. It is significant to note that the Florida Medical Association, by its actions in this case, has brought about a definitive statement in a new area of the law.

2. Department of Justice Antitrust Investigation

The Department of Justice commenced an Antitrust Investigation of the Florida Medical Association in January of 1978. These investigations requested discovery of files and information relative to conduct perceived by the Antitrust Division to be a restraint of trade in the provision of medical services to members of this Association. The thrust of the investigation was directed towards the Florida Medical Association Ethical Criteria for Hospital Based Physician Contracts. This particular policy was revised by the House of Delegates in May of 1979. We have called on the Department of Justice to dismiss this investigation and on August 21, 1980 we were so notified that the matter had been officially closed by the Department of Justice on July 17, 1980.

3. Department of Professional Regulation

During the 1979 Session of the Florida Legislature a law was enacted that required the Department of Professional Regulation to require licensees and licensed establishments under their jurisdiction to post a sign in a conspicuous place that notifies individuals of a number they may call if they have a complaint. The Board of Governors authorized us to seek legal action to enjoin this particular activity. The Department, with the knowledge of our pending legal action, withheld enforcement of this particular statute as it relates to the medical profession and during the 1980 legislature this particular provision of the Department of Professional Regulation Act was repealed.

4. Davidson, Coria v. FMA, PIMCO, FPIR

This is an action by two Key West physicians alleging that they were improperly terminated by the Florida Physicians' Insurance Reciprocal. This matter has been extensively investigated and at one time trial was commenced only to be ended by a mistrial based upon an improper statement by a plaintiff's attorney. Since the mistrial, additional discovery has been concluded. Also during this period of time the trial Judge has excused himself because he was a witness to an incident involving a plaintiff's attorney and a potential

witness on behalf of the Florida Medical Association. This matter has now been reassigned to a new Judge and it is anticipated that the matter will go to trial sometime in April 1981.

5. FMA v. HRS (Release of Medicaid Fee Information)

In February of 1980, FMA learned of a request by a television station, made to the Department of HRS, for Medicaid Fee Information and specifically physician names and fees charged. Based upon our previous activity in this similar kind of area, we were authorized by the Board of Governors to seek a temporary restraining order and a permanent injunction against the release of this information. Subsequent to this lawsuit being filed, the request for this information was withdrawn. However, it was the feeling of the Department of HRS that there was a need to clarify the law in this matter and they requested an Attorney General's opinion. The Attorney General rendered his opinion on April 10, 1980 and in essence ducked the question leaving it to the discretion of a court to prohibit such disclosure. The Department has agreed to advise FMA of any request for disclosure in the future so that we may take necessary legal action to bring this matter to the courts for a final decision.



JFMA Editor Daniel B. Nunn, M.D., Jacksonville, holds a photograph entitled "Trick or Treat" which won the Editor's Award in the Auxiliary Art Exhibit. As the Editor's Award winner, the photograph serves as the cover for this issue of *The Journal*. Here, Dr. Nunn congratulates the photographer, Lee A. Fischer, M.D., West Palm Beach.

SECOND HOUSE OF DELEGATES

6. Optometrists Lawsuit re Drug Prescribing

The Board authorized the FMA to actively support the position of the Florida Society of Ophthalmologists in the lawsuit filed by the Florida Optometric Association against the Florida Department of Professional Regulations and the Board of Pharmacy regarding the prescribing and use of noncontrolled drugs and that FMA seek to intervene in the lawsuit and to authorize FMA Legal Counsel to assist the ophthalmologists and the Board of Medical Examiners in the preparation and presentation of necessary testimony and legal arguments in opposition to the position of the Florida Optometric Association and that the use of outside legal counsel be authorized as necessary and further that Mrs. Nancy Wittenberg, Secretary to the Department of Professional Regulations, be provided with a summary of FMA's position regarding this issue.

7. Dual Fee Schedules

The Board reaffirmed the current FMA position of opposition to the application of Specialty Screens (Dual Fee Schedules) in Florida and also directed that FMA, if invited, participate in the defense of the lawsuit filed by the Dade County Society of Internal Medicine against Blue Cross/Blue Shield of Florida, GHI and the Department of HHS, and that FMA's participation would be for the purpose of defending the position which has been adopted and reaffirmed by the FMA House of Delegates in opposition to specialty screens.

8. Release of Physicians' Names and Fees Under Medicaid

This action was a result of a request received by the Department of HRS from the *St. Petersburg Times* for a list of all providers, including physicians, who participate in the Medicaid program in the Pinellas County area and the amounts paid to them during the last quarter. The Department had advised FMA of the request as a courtesy in the event that FMA may wish to take some action. This was due to a similar situation which occurred last February, when a request for this information was filed by a Fort Myers newspaper with the Department, but never subsequently followed up on. At that time, the Board authorized that appropriate legal action be taken to prohibit release of this information.

With regard to the current action, FMA Legal Counsel, with the assistance of the law firm Mahoney, Hadlow and Adams, caused an action to be filed in the U.S. District Court in Tallahassee before Judge William Stafford on Friday, March 20. This action sought to enjoin the Department from releasing this information. We are relying substantially on the precedent set by the injunction against HEW for releasing physicians' names and fees under Medicare to support the current action.

The judge has granted a temporary restraining order and a full hearing was scheduled for Friday, March 27. (Updated information on this action will be included in the Board's supplemental report to the House.)

Board Actions of Major Importance

House of Delegates Ratio — The Board approved the ratio for determining Delegates for the 1981 House of Delegates remaining at one for every fifty active members of the Association within each county medical society, and one for any fraction over and above the last complete list of fifty.

FMA Annual Meeting - Blue Shield Informational Meeting — The Board approved a Blue Shield informational meeting for the FMA membership to be held at 8:00 a.m. on Thursday, April 30, in conjunction with the 1981 FMA Annual Meeting.

Future Meeting Dates — The Board approved changes, where possible, for future annual meetings dates to avoid conflicting with Mother's Day.

FMA Annual Meeting	May 5-9, 1982
FMA Annual Meeting	May 4-8, 1983
*FMA Annual Meeting	May 2-6, 1984
FMA Annual Meeting	May 1-5, 1985
*FMA Annual Meeting	May 14-18, 1986
*FMA Annual Meeting	May 13-17, 1987
*FMA Annual Meeting	May 11-15, 1988

*new dates to avoid conflicting with Mother's Day

1982 Annual Meeting — The Board reviewed the previous actions taken by the House of Delegates and the Board of Governors regarding alternate locations for the Annual Meeting, and specifically, the selection of the Sheraton Twin Towers in Orlando as the site for the 1982 Annual Meeting.

A major factor affecting the decision to secure alternate meeting sites has been a continuing decline in attendance at the Annual Meeting as a percentage of the total FMA membership. The following figures reflect membership and physician attendance at the Annual Meeting for the past five years:

Year	Total Membership	Annual Meeting Physician Attendance
1976	10,354	1,753 (16.9%)
1977	11,447	1,658 (14.5%)
1978	12,172	1,468 (12%)
1979	12,684	1,478 (11.6%)
1980	13,389	1,369 (10.2%)

One of the reasons cited as a possible factor has been the dissatisfaction with the meeting continually being held in the South Florida area. Of course, the reason for this South Florida location has been that no other area in the State had facilities under one roof adequate for the FMA's meeting requirements, i.e., adequate number of sleeping rooms and suites, multiple meeting rooms, exhibit space, accessibility and appeal.

In 1979, the FMA House of Delegates confirmed future Annual Meeting dates through 1986 at the Diplomat Hotel until such time as a suitable alternate location became available. The Board of Governors, at its meeting in June 1980, in discussing proposed Annual Meeting dates, directed that the location for the Annual Meeting be moved from the Diplomat to the Sheraton Twin Towers at the earliest possible date. Pursuant to this action, FMA staff met with representatives at the Sheraton Twin Towers to negotiate dates and arrangements and to determine if in fact the facilities were adequate. The Board at its meeting in October 1980, was advised that meeting dates were available in 1982 for the period of May 19-23, that the meeting and exhibit space were adequate; however, there were concerns with regard to the total number of sleeping rooms in the hotel (700), as well as the number of suites. It would be necessary to utilize the Howard Johnson's and/or the Court of Flags to house the overflows which could be substantial. Also, restaurant facilities were somewhat limited and could be a potential problem. Overall, it was the feeling of the Board that the meeting could be held at the Sheraton Twin Towers with the knowledge of these potential problems. The Board directed that the 1982 Annual Meeting be held at the Sheraton Twin Towers subject to negotiation of a satisfactory contract.

At its meeting in March, the Board received a recommendation that the Board reconsider its previous action and defer moving the Annual Meeting to an alternate location until such time as more adequate facilities are available. It was pointed out that there were plans to construct an additional tower at the Sheraton Twin Towers which would make this location more feasible. There is also a major hotel currently under construction in Tampa that may be suitable as an Annual

SECOND HOUSE OF DELEGATES

Meeting site.

After careful deliberation, the Board approved a recommendation that the 1982 Annual Meeting be held at the Diplomat in lieu of the Sheraton Twin Towers in Orlando as previously approved by the Board. This action was taken in the best interests of the membership to insure that the facilities selected for the Annual Meeting are adequate to serve the many diversified meeting requirements of the FMA, its county medical societies and related organizations who participate in the Annual Meeting. The Board reaffirmed the desire expressed by the House of Delegates to secure, at the earliest possible date, alternate locations for the Annual Meeting in the Central Florida area.

FMA Travel — Authorized FMA sponsorship of medical seminar travel proposals for 1981 to include the Ireland/British Isles Adventure, July 1981, and the Western Mediterranean Air/Sea Cruise, October 1981.

AMA Jail Project — Authorized the Florida Medical Foundation to continue participation in the AMA Jail Project for conducting an evaluation of health care in selected Florida jails for an additional year.

PMUR/Medicare — After a brief interruption in peer review activities in the state, the Board entered into an agreement with Blue Cross and Blue Shield to continue peer review activities in Florida with the exception of Dade and Monroe Counties. Group Health Inc., of Miami indicated that it would not renew the contract with the Foundation to continue peer review in these counties.

PMUR/Medicaid on Workers' Compensation — The Board approved renewal of the agreement between the Florida Medical Foundation and the Department of HRS to provide peer review for Florida's Medicaid program and approved the contract between the FMF and the Division of Labor to provide peer review activities for Florida's Workers' Compensation Program.

AMA Vice Speaker — The Board enthusiastically endorsed the candidacy of Florida AMA Delegate, Rufus K. Broadaway, for election to the office of Vice Speaker of the AMA at the 1981 Annual Meeting and authorized funds for conducting the campaign.

FMA Auxiliary — Expressed appreciation to the FMA Auxiliary for their continuing fine efforts on behalf of the FMA and the Florida Medical Foundation particularly with regard to legislative educational activities, support of the Impaired Physicians Program and fund raising efforts on behalf of the Florida Medical Foundation.

F.M.M.J.U.A. — The Board approved, in principle, support for the continuance of the Florida Medical Malpractice Joint Underwriting Association, subject to the provisions of the final extending legislation, to insure professional liability insurance protection for those physicians who are unable to obtain coverage from alternate sources.

AMA Resolution on CME — The Board received as information a report of the actions of the AMA House of Delegates at its meeting in July 1980, adopting a resolution calling for a moratorium on all additional mandatory continuing education and reexamination or recertification programs pending evidence of their effectiveness in upgrading the competence of physicians.

AMA Speakers Bureau Awards — Acknowledged with commendation that two Florida physicians have been awarded prizes for entries in the AMA Speakers Bureau contest; Dr. Edward Annis of Miami placed 2nd in the category of Television Talk Show guest and Dr. Luis Perez of Sanford placed 3rd in the category of Television Talk Show host.

AMA Dues Remittance Procedures — The Board reaffirmed the current procedures as outlined in the AMA and FMA Bylaws for processing AMA membership and dues through the state society.

Meeting with Governor Graham — During the 1981 Leadership Conference, a small group of FMA officers and staff met with Governor Bob Graham following his presentation at Saturday's luncheon. It was a productive meeting and achieved the purpose of developing a closer relationship with the Governor. FMA's representatives expressed appreciation to the Governor for allowing the Recovery of

Costs Bill, passed during the 1980 Legislative Session, to become law and discussed FMA budget priorities. Concern was expressed regarding development throughout the State of business health coalitions and the lack of physician participation in a policy making role.

The Governor asked FMA assistance in identifying changes at the Federal level in health budget support and the impact those changes being proposed by the Reagan administration would have on current state budget decisions. He also asked for our assistance in reviewing two areas:

- A. Relationship between the state and hospitals providing educational support services — residencies, etc. (The University Hospital in Jacksonville is an example)
- B. The State's assistance to medically indigent for catastrophic illness. Now we are taking a categorical approach — burn centers, cancer, etc. This should be viewed in terms of comprehensive, rather than categorical, assistance.

With regard to the national health program issues, FMA provided the Governor, with the assistance of the AMA, detailed information regarding health budget cuts and the transfer of program responsibility to the State. Our staff will maintain close liaison with the Governor's office regarding these and the other issues that were discussed.

AMA Leadership Conference — Florida was well represented at the AMA Leadership Conference held in Chicago, February 12-15. The program content was generally excellent and it should be particularly noted that Dr. Hodes in his position as President of the National Conference of State Legislators was a featured luncheon speaker and made one of the most outstanding presentations of the entire Conference.

Government Programs — The Board reviewed a report regarding the actions of the AMA House of Delegates, taken at its Interim Meeting, December 7-10, 1980, including:

- Support for immediate cessation of funding for P.L. 93-641 and P.L. 96-79 and direct AMA efforts towards repeal of these laws with the request for support from state medical associations.
- Authorized investigation of the feasibility of an AMA in-depth study of the element of competition introduced in the health care delivery system by HMO's and other pre-paid plans.
- Reaffirmed current policy on national health insurance which is to continue to advocate the principles embodied in Resolution No. 62.
- The elimination of all federally controlled PMUR programs and reiterated the AMA position to continue professionally directed efforts to insure that care provided to patients is of high quality, appropriate duration and rendered in an appropriate setting at a reasonable cost.

RECOMMENDATION NO. A-5

ADOPTION OF GUIDELINES TO BE UTILIZED BY THE COMMITTEE ON NATIONAL LEGISLATION IN WORKING TOWARD ACCOMPLISHING CHANGES IN THE FUTURE DIRECTION OF FEDERAL GOVERNMENT PROGRAMS INCLUDING:

1. REPEAL OF P.L. 93-641 AND THE ELIMINATION OF HSA'S WITH FUTURE APPROPRIATE HEALTH PLANNING ACTIVITIES TO BE CARRIED OUT BY STATE AND LOCAL GOVERNMENTS.
2. THE ELIMINATION OF PROFESSIONAL STANDARD REVIEW ORGANIZATIONS WITH SUPPORT FOR SUITABLE M.D.-CONTROLLED ALTERNATIVES FOR PSRO'S.
3. THE ELIMINATION OF FEDERAL SUBSIDIES FOR THE UNFAIR PROMOTION OF HMO'S AS A MORE ECONOMIC ALTERNATIVE TO

OTHER PRIVATE HEALTH CARE DELIVERY MECHANISMS.

4. **DISCONTINUANCE OF THE PRACTICE OF THE NATIONAL HEALTH SERVICE CORPS OF PLACING NATIONAL HEALTH SERVICE PHYSICIANS IN POSITIONS IN WHICH THEY ARE IN COMPETITION WITH PRIVATE PRACTITIONERS OF MEDICINE.**

Medical and Health Yellow Pages for South Florida — The Board approved a recommendation not to endorse the publication entitled "Medical and Health Yellow Pages for South Florida" and directed that the membership roster of the Florida Medical Association not be given or sold to the organization publishing this directory.

Bylaws Amendments —

RECOMMENDATION NO. A-6

THAT THE FOLLOWING AMENDMENTS TO THE FMA BYLAWS BE ADOPTED:

Chapter VII, Board of Governors — Section 2, Duties and Functions:

"11. The Board shall maintain standing committees on:

1. AMA Delegates
2. Board of Past Presidents
3. ~~County medical societies~~
4. FMA Speakers Bureau"

Chapter VII, Councils — Section 1, Organization:

"Directly responsible to and reporting through the Executive Committee to the Board of Governors shall be the following Councils:

1. Judicial
2. Legislation
3. ~~Medical Economics~~
3. Health Care Financing
4. Medical Services
5. ~~Government Programs~~
5. Scientific Activities
6. Specialty Medicine

Chapter VII, Councils — Section 3, Duties, Functions and Composition:

~~"3. The Council on Medical Economics shall . . .~~
(delete the remainder of the paragraph.)

~~"5. The Council on Government Programs shall . . .~~
(delete the remainder of the paragraph.)

"3. The Council on Health Care Financing shall monitor such programs as health systems agencies, Workers' Compensation, Medicare, Medicaid, and other government health care programs, and shall maintain liaison with the government agencies administering them. It shall maintain liaison with health insurance agencies, advise on industrial medicine relations and the cost of medical care, and shall serve as a clearing house on fee schedules and other questions affecting the economics of medicine. It shall reports its activities regularly to the Board of Governors through the Executive Committee."

Chapter X, Income and Expenditures — Section 2, Dues:

"1. Annual Dues. — Annual dues shall be assessed, ~~as hereinafter provided~~, as recommended by the Board of Governors and approved by the House of Delegates and shall currently be \$175.00 per year (\$50.00 of which from active members is to be earmarked for public relations and legislative educational activities) ~~for active members, \$50.00 per year for associate members, \$10.00 for medical interns and full time physicians in an approved residency or internship, and \$10.00 per year for medical students.~~ Payment of dues for all classes of membership shall include a subscription to *The Journal of the Florida Medical Association* and one copy of *The Florida Medical Directory* for the current year; and shall include an amount for a pre-paid life-time subscription for the above publications in the event the physician remains a member and is excused from payment of dues for any reason."



As *The Journal's* newest Assistant Editor, Francis C. Coleman, M.D., Tampa, is keeping an eye out for any newsworthy picture opportunities.



Edward R. Annis, M.D., Miami, Past President of the American Medical Association, makes an important point to Speaker of the House James B. Perry, M.D., Fort Lauderdale (left); and Jere W. Annis, M.D., Lakeland (center).

Report F of the Board of Governors

Report F of the Board of Governors was adopted.

Report F of the Board of Governors T. Byron Thames, M.D., Chairman

The following supplemental report of the Board of Governors has been prepared summarizing actions which were not included in the Board's report in the Delegates' Handbook.

Committee on Membership and Discipline

In compliance with the Bylaws, the Board has reviewed terms expiring in 1981 on the Committee on Membership and Discipline. Nominations from county medical societies have been considered, and the Board nominates the following physicians for election to the

Committee on Membership and Discipline for the terms indicated.

District 1	Herbert E. Brooks, M.D. (85)
District 2	James K. Conn, M.D. (85)
District 3	Joe C. Ebbinghouse, M.D. (85)
District 4	Samuel L. Renfroe, M.D. (85)
District 5	Frederick Weigand, M.D. (85)
District 6	Royce Hobby, M.D. (85)
District 7	Jeff W. Harris, M.D. (85)
District 8	James D. Morgan, M.D. (85)
District 9	Richard Neil Baney, M.D. (85)
District 10	Martin E. Mihm, M.D. (85)
District 11	Reginald J. Stambaugh, M.D. (85)
District 12	Robert J. Brennan, M.D. (85)
District 13	Maurice H. Laszlo, M.D. (85)
District 14	Richard M. Fleming, M.D. (85)
District 15	John D. White, M.D. (85)

FMIT Program

After considerable study the Board of Governors authorized the Trustees of the Florida Medical Insurance Trust to make a change in the group health insurance and group life program formerly written by Blue Cross/Blue Shield and American Bankers Insurance Company.

The new underwriters have designed a comparable plan through the use of a self-insured fund. In order to protect the Fund, a reinsurance contract has been developed that would limit the losses and save the participants premiums as compared to the present fully insured plan. Rates, which vary with the applicant's age, are lower than under the previous plan.

Department of HRS — Release of Physicians' Names and Fees under Medicaid

The FMA filed an action in the U.S. District Court in Tallahassee before Judge William Stafford on Friday, March 20, 1981 seeking to enjoin the Florida Department of Health and Rehabilitative Services from releasing the names of physicians and fees paid to them under Florida's Medicaid program. This action was a result of a request received by the Department from the *St. Petersburg Times* for a list of all providers including physicians who participate in the Medicaid program in the Pinellas County area and the amounts paid to them. The Department had received a similar request from the *Lakeland Ledger*.

The FMA, in filing this action, relied substantially on the precedent set by the injunction that had been granted earlier against the U.S. Department of Health and Human Services (then HEW) to support the current action. Judge Stafford granted a temporary restraining order and a full hearing was scheduled for Friday, March 27. Following that hearing, the restraining order was continued to allow the Judge time to review the contract between the HHS and the Department of HRS, for administration of Title 19, which is the Medicaid law. He also reviewed appropriate rules and regulations for the purpose of determining whether or not there were substantive, correlating provisions which would subject the Department of HRS to the federal law and substantiate FMA arguments that the Freedom of Information Act and the Privacy Act are applicable to the Medicaid program.

Judge Stafford, on Thursday, April 9, denied FMA's Motion and dissolved the temporary restraining order which had prevented HRS from divulging the information requested. The Judge advised that he could find no congressional intent to apply the Privacy Act to the Medicaid program and, further, that he could find no requirement to maintain financial records regarding payment to physicians pursuant to the contract between HHS and HRS. Consequently, no exception to the Privacy Act can exist. With the assistance of legal counsel, the FMA is evaluating the feasibility of any further action which might be taken.

FMA Finances

The report and recommendations of the Board of Governors to the House of Delegates includes a recommendation for an increase in FMA dues for active members beginning in 1982. To assist Delegates in evaluating the Board's recommendation, a copy of the report of the Special Committee of the Board of Governors on Finance, chaired by Dr. Jere W. Annis, which was adopted by the House of Delegates at its meeting in May 1980 is included in the Delegates' packets.

Report of Public Relations Officer

The Report of the Public Relations Officer was adopted.

Report of Public Relations Officer

Vernon B. Astler, M.D., Public Relations Officer

As we enter the decade of the 80's, physicians in organized medicine are being challenged by the media, government, independent critics and from consumer groups. Activism has made public relations an essential and valuable tool to all physicians. During this era of activism, we can no longer rely upon our work or the product of our labor to speak for itself. We must respond through public relations efforts if we are to persuade the public and our patients to our point of view.

FMA's attitude is to turn this challenge into an opportunity to educate the public on how to better look after its own health. In order to accomplish such a program, first there must be a flow of information to the individual physician for he/she is the foundation of medical public relations.

During the past three years the Association's annual theme has dealt with the subjects of Nutrition, Physical Fitness/Lifestyle and Stress. Our scientific sections each year has focused attention on these programs for the entire membership. At the same time FMA has translated much of this into consumer education utilizing all elements of the media — television, radio and print. The Association has released films and television public service announcements covering medical technology advances, nutrition and the results of bad lifestyle. Our program has and will always continue to put forth the image of physicians as dedicated, caring people.

FMA's latest film, *Edge of Life* shown statewide in January of this year, dealing with emergency room situations, is an outstanding example of this effort. The Ft. Myers News Press said: "The film is peppered with memorable moments." "Through it all you will be impressed by the importance of the human touch in an age of technology," commented the Pensacola Journal. The Tallahassee Democrat said the film emphasizes "the complex relationship between doctor, patient, and technology that must all come together in the emergency room," while the Palm Beach Post commented "Edge of Life is a sharp reminder there is a world of difference between taking up an emergency room physician's time with someone who's had a rash for two months and someone whose life hangs in the balance following a car crash." A number of other publications previewed the film and all commented favorably. We accomplished our goal.

Since then, a new campaign has been launched with the state's television stations and newspapers. Governor Bob Graham declared March as "Living Well in Florida Month." In cooperation with this program, FMA developed a series of "health hints" done in cartoon form. These were distributed to newspapers for publication and as 35mm

slides to TV stations for broadcast purposes. FMA is identified throughout the campaign and delivers a positive message on preventive medicine.

An expanded effort to disseminate information regarding these activities and all major actions by the FMA to the membership has been implemented. Immediately following each meeting of the Board of Governors, county society executives are invited to attend an executive staff briefing. A member of the Board of Governors is present at these sessions to explain policy actions as well as receive input from the county society. In addition, there has been a strong visitation program this year to county societies and specialty groups by officers, members of the Board of Governors and appropriate staff. In numerous instances, the FMA Speaker's Bureau has worked with and provided programs for county societies.

With the assistance of the FMA field staff, the state's media is monitored on a daily basis. When needed, the instant response network disseminates the Association's position on given statewide issues in 24 hours or less. Annual visitations to meet with editors and publishers of the state's largest circulation dailies began in 1979 and proved productive again this year. This is borne out by the fact that FMA is being called upon more and more as a resource for opinions on issues affecting the health of the public.

The staples of the program continue to be the medical message columns and radio public service announcements. Surveys reveal continued high utilization of the columns by small dailies and the weekly newspapers. The teenage high school newspaper column has brought numerous letters and requests for information from both students and counselors.

During the year surveys did reveal a program format change by a majority of the state's radio stations. Consequently, FMA immediately terminated its five minute programs and is now supplying seven one-minute question and answer health messages to the stations on a monthly basis. This change brought about a large increase in utilization of the material furnished by FMA.

The FMA now enjoys direct input to the Board of Directors of the Florida Association of Broadcasters. FMA's Director of Communications became the first non-broadcaster in the history of the organization to be selected to serve on the Board.

Still another public relations function is the annual Excellence in Medical Journalism Contest that climaxes during the Annual Meeting with a presentation of awards. Categories to honor outstanding journalists include radio, newspaper, magazines and television. This year over fifty outlets were represented in the competition.

The very backbone of the public relations program will always be the physician and the doctor/patient relationship. The continuing cooperation of each FMA member is the most essential element of the public relations program.

Committee on AMA Delegates

The Reference Committee congratulated all AMA Delegates on their service to FMA and to medicine as a whole, and particularly commended Dr. James T. Cook Jr., retiring Chairman, for his many years of excellent service.

The Report of the AMA Delegates was adopted.

AMA Delegates

James T. Cook Jr., M.D., Chairman

It has been my pleasure to once again serve as Chairman of the

AMA Delegates during the past year and I greatly appreciate the assistance of the Vice Chairman, Joseph C. Von Thron, M.D., Cocoa Beach. I wish to thank all of our delegates who have given of their time and efforts in support of the best interests of Florida's physicians in the AMA House of Delegates: Rufus K. Broadaway, M.D.; Richard G. Connar, M.D.; Samuel M. Day, M.D.; Charles K. Donegan, M.D.; Joseph C. Von Thron, M.D. I would like to pay special thanks to our alternate delegates for their interest and full attendance at all meetings and for their assistance at Reference Committees and at Sessions of the House of Delegates: Vincent P. Corso, M.D.; Eugene G. Peek Jr., M.D.; T. Byron Thames, M.D.; William J. Dean, M.D.; Francis C. Coleman, M.D.; Luis M. Perez, M.D.; and Vernon B. Astler, M.D. Robert J. Brennan, M.D., representing Allergy, and Thomas D. Bartley, M.D., representing Thoracic Surgery, have participated in our caucuses and have been a positive influence in enhancing Florida's overall strength in the House of Delegates.

Particular note should be made that a number of FMA Officers and Board members and officers of component county medical societies have attended the meetings and supported the efforts of your Delegation.

Florida's Delegation continues to enjoy a strong voice in the House of Delegates and several of our delegation hold important council and committee assignments: Burns A. Dobbins, M.D., AMA Judicial Council; Rufus K. Broadaway, M.D., AMA Council on Long Range Planning and Development; Richard G. Connar, M.D., Member, Council on Medical Education. Several of our delegates have served on Reference Committees at the Annual and Interim Meetings of the House.

The number and gravity of the issues that continue to face organized medicine have been reflected in the large volume of issues to come before the House — issues that demonstrate all too clearly the ever present threats to the quality of medical care and our private system of health care delivery. I am pleased to report that the House of Delegates has responded in a firm and positive manner to a number of crucial issues, including PSRO's, Health Planning, HMO's and others, which will be reported on in more detail later in this report.

The following is a summary of the activities of your Florida Delegation during the past year, including the Annual Meeting, July 20-24, 1980, in Chicago, and the Interim Meeting, December 7-10, 1980, in San Francisco. Your delegates have submitted written reports on activities both at meetings of the Board of Governors and to the FMA membership through FMA publications.

Candidates for Elective Office

The Board of Governors at its meeting in June endorsed the nomination of Charlotte H. Kerr, M.D., of Seminole County, for election to the AMA Council on Constitution and Bylaws, and Henry D. McIntosh, M.D., of Lakeland, to the AMA Council on Scientific Affairs. A letter of support for their candidacy was sent to all AMA Delegates and they were provided with assistance during the Annual Meeting in Chicago in scheduling appearances before state delegations. While neither Dr. McIntosh nor Dr. Kerr were elected, it should be noted that both these physicians were newcomers, running for AMA elective office for the first time and that there was much formidable opposition in that many of the candidates were members of the respective councils running for re-election.

AMA Vice Speaker, 1981

With the full approval of the Board of Governors, the Florida Delegation has unanimously and enthusiastically expressed its support for the election of Rufus K. Broadaway, M.D., as Vice Speaker of the House at the 1981 Annual Meeting. A Campaign Committee has been appointed and is comprised of the following physicians: Francis

Coleman, M.D., Chairman; T. Byron Thames, M.D.; Edward Annis, M.D.; and Robert J. Brennan, M.D. Don Jones has been requested to provide staff assistance to the Committee. A letter announcing the Florida Medical Association and Florida Delegation's intention of placing Dr. Broadaway's name in nomination for this office has been sent to all AMA Delegates and an active campaign is currently underway.

Florida AMA Delegation — Chairman and Vice Chairman

Your Chairman was honored to accept re-election as Chairman of the Delegation for 1980-81. I am pleased to share this responsibility with Joseph Von Thron, M.D., who was re-elected as Vice Chairman of the Delegation.

House of Delegates Actions Re Florida Resolutions

Florida Resolutions

Following the instructions of the FMA House of Delegates at its meeting in May, three Resolutions were introduced by the Florida Delegation at the AMA Annual Meeting in July: Resolution #36, Drug Abuse Programs; Resolution #37, Economics Related to Cigarette Smoking; and Resolution #38, Medicare Reimbursement of Hospital Based Physicians. In addition, the Florida Delegation approved a Resolution to be submitted by the Delegation that was proposed by Charles Donegan, M.D., Resolution #68, HMO Promotion Under Medicare. At the Interim Meeting of the House in December, the Delegation submitted Resolution #59, Non-Physician Measurement of Body Functions. The following is a summary of the action taken by the House on each Resolution:

Resolution #36

Drug Abuse Programs

RESOLVED, That the American Medical Association establish on a nationwide basis, a program which would reduce the abuse of amphetamines and methaqualones, the incidence of stolen and forged prescriptions, and pharmacy burglaries, such program to include:

1. A 48 hour delay in delivery of amphetamine or methaqualone prescriptions and that these drugs no longer be stocked routinely in pharmacies.
2. Each prescription be verified by a telephone call to the doctor personally.
3. Physicians reminded to guard carefully their prescription blanks and to take precautions against forgeries and that they not have the narcotic control number (DEA) pre-printed on the form.
4. The assistance and cooperation of local pharmacy associations and law enforcement agencies be enlisted.

Referred through the Board of Trustees to the Council on Scientific Affairs. It was the feeling of the Reference Committee that this should be studied by the Council on Scientific Affairs prior to commitment of AMA to any particular program.

Resolution #37 Economics Related to Cigarette Smoking

RESOLVED, That the American Medical Association aggressively pursue all avenues of educating the general public through nationwide educational programs and projects as to the hazards of cigarette smoking emphasizing all facets of the high cost of this most serious preventable medical problem.

This Resolution was adopted as presented.

SECOND HOUSE OF DELEGATES



The winners of the Medical Golf Tournament received their awards during a session of the House of Delegates. Several physician golfers received trophies, including Past President Joseph C. Von Thron, M.D., Cocoa Beach (left); and Thomas Civitella, M.D., Port Charlotte (right). With them is FMA President T. Byron Thames, M.D.

Resolution #38 Medicare Reimbursement of Hospital Based Physicians

RESOLVED, That the American Medical Association continue to oppose the proposed "uniform implementation" of the Medicare regulations dealing with hospital-based physicians as set forth in the March 11 issue of the Federal Register (45 FR 155550).

The House considered Resolution #38 along with Resolution #7, "Opposition to HCFA Regulations" and adopted Substitute Resolution #7 in lieu of Resolutions #7 and #38.

Resolution #68 HMO Promotion Under Medicare

Adopted:

RESOLVED, That the AMA again urge the Health Care Financing Administration to cease the use of public funds to promote enrollment of Medicare beneficiaries to HMO's over other forms of health care and delivery, and that if this cannot be implemented, that legislation be introduced and supported through Congress to prevent the use of public funds to promote enrollment of Medicare beneficiaries to HMO's over other forms of health care and delivery.

Resolution #59 Non-Physician Measurement of Body Functions

RESOLVED, That in the public interest, the American Medical Association emphasize that non-physician health care providers are not competent or trained to diagnose or to treat any abnormal conditions of the vascular and endocrine systems; and be it further

RESOLVED, That in the public interest, the American Medical Association recommend that non-physician health providers who perform tests such as blood pressure or blood sugar measurements advise the examinee to communicate

these findings to a licensed physician.

The House adopted Substitute Resolution 59A as recommended by the Reference Committee and which was concurred in by the Florida Delegation.

RESOLVED, That in the public interest, the American Medical Association emphasize that non-physician health care providers are not educated or trained to diagnose or to treat any abnormal conditions of the vascular and endocrine systems; and be it further

RESOLVED, That in the public interest, the American Medical Association recommend that non-physician health providers who perform tests such as blood pressure or blood sugar measurements advise the examinee to communicate these findings to a licensed physician.

Southeastern Delegation

The Board of Governors at its meeting in October 1979 authorized your Delegation to participate in the Southeastern Delegation for one year, to be effective with the July 1980 Annual Meeting. Other members of the Delegation include: Alabama, Delaware, Georgia, Louisiana, Maryland, Mississippi, South Carolina, North Carolina, Virginia and the District of Columbia. Your Delegates participated in caucuses with the Southeastern Delegation at the Annual and Interim meetings of the House. The primary purpose of these caucuses was to interview candidates for AMA elective office and discuss major issues to be addressed by the House. The Delegates also participated in receptions sponsored by the Southeastern Delegation at both meetings.

House Actions of Major Importance

Professional Standard Review Organization

By a vote of 104 to 100 the House voted to encourage elimination of all federally controlled Peer Medical Utilization Review programs and reiterated the AMA position to continue professionally directed efforts to ensure that care provided to patients is of high quality, appropriate duration and rendered in an appropriate setting at a reasonable cost.

Health Planning Activities (HSA's)

The House adopted a Resolution supporting immediate cessation of funding for P.L. 93-641 and P.L. 96-79 which also directed that the AMA cause legislation to be introduced in the 97th Congress to repeal these laws and to request the support of the state medical associations in seeking passage of this legislation. It was further resolved that because there are differences in sections throughout the country, where State and regional attitudes and directives pose specific problems with regard to planning, that the medical profession should accept responsibility and assume a position of leadership. The Resolution further directed that the AMA develop principles for a program of voluntary, locally-based health planning, designed to address local needs with local resources as an alternative to P.L. 93-641 and P.L. 96-79.

HMO's

The House voted to authorize the AMA to investigate the feasibility of an in-depth study of the element of competition introduced into the health care delivery system by HMO's and other pre-paid plans. The House accepted a report regarding implementation of Resolution 68, HMO Promotion Under Medicare, introduced by the Florida Dele-

gation at the 1980 Annual Meeting and summarizing the dialogue that has taken place during 1979-80 by the AMA and HCFA concerning mailings to Medicare beneficiaries about HMO's. It was noted that there has been success in modifying the language of notice to clarify the fact that beneficiaries have a choice among health care delivery systems and do not advocate one system over another. To the extent that information is available, AMA will inform medical societies when mailings are going to be made in their areas. The House re-affirmed the position "that approval of the concept of neutral public policy and fair market competition among all systems of health care delivery continue to be AMA policy, with the potential growth of HMO's being determined not by federal subsidy, preferential federal regulations, and federal advertising promotion, but by the number of people who prefer this mode of delivery."

National Health Insurance

The House re-affirmed the AMA's current policy of National Health Insurance which is to continue to advocate the principles embodied in Resolution 62. The AMA will continue to pressure in a positive manner the superiority of a voluntary, free-choice method of medical and health care delivery, as opposed to a system dominated and controlled by the federal government.

Accreditation for Medical Education

Approved the initiation of discussions and negotiations between AMA and other organizations to revise accrediting structures in medical education. In taking this action, the House acknowledged the dual system which currently exists and the desirability for a single CME accrediting mechanism provided that any such mechanism allowed intra-state accreditation by state societies. The House opposed the AMA developing any centralized repository on CME on individual physicians.

Joint Commission of Accreditation of Hospitals

Voiced criticism of some of the policies of the Joint Commission of Accreditation of Hospitals and referred to the Board a number of Resolutions regarding the inconsistent interpretation of standards. The House adopted Resolution #81 and directed the Board to:

- Initiate meetings with other sponsoring groups to discuss its concerns about JCAH and to explore methods of improving the accreditation process.
- Recommend that the JCAH Board of Commissioners rewrite standards to eliminate ambiguities and to increase flexibility in implementing standards.
- Recommend the JCAH Board emphasize the improvement of the quality of the survey and accreditation process in short-term, acute-care facilities.
- Recommend the commissioners reconsider the desirability of continuing to survey long-term facilities not affiliated with hospitals.
- Recommend the commissioners streamline the accreditation process by such methods as contracting with a management firm to perform accreditation and extending the term of accreditation from two to three or four years.

Mandatory CME

Adopted Resolution #102 calling for a moratorium on mandatory CME or any mandatory re-examination or recertification programs pending evidence of their effectiveness of upgrading the competence of physicians.

Medicare Reimbursement

Reaffirmed current Association policy supporting the UCR concept and continuation of efforts to ensure equitable reimbursements of Medicare and Medicaid.

Medical Ethics

Adopted a new code of Medical Ethics, the first revision to the Principles since 1957. The Principles established broad areas of responsibility for all physicians with emphasis on the belief that ethical standards should be for the benefit of the patient.

Chiropractic

Approved an independent and impartial study conducted by an appropriate agency to evaluate the efficacy and safety of chiropractic.

Other Actions

In other actions, the House:

- commended the Board of Trustees for its financial leadership and accepted a recommendation to hold the dues at the current level for 1981.
- encouraged continued dialogue between physicians and other health care practitioners at the state and local levels to determine the extent of responsibility and scope of functions to be assumed by such practitioners.
- noted the satisfactory progress in the AMA Program for Voluntary Fee Restraints and reaffirmed AMA's continued commitment to the Program.
- approved a report supporting AMA's contention that the Federal Trade Commission does not have jurisdiction over a non-profit organization such as the AMA.

FMA Speaker's Bureau

The Report of the FMA Speaker's Bureau was adopted.

FMA Speaker's Bureau

Edward R. Annis, M.D., Chairman

Credibility for the views and statements of organized medicine came to the forefront during the year as members of the Speakers Bureau composed of officers and the Board of Governors addressed a multitude of groups.

Statements, based upon documented facts prepared by physicians and members of the staff, achieved this result. Perhaps the most significant was medicine's clear-cut victory on all counts in the recent Chiropractic lawsuit in Chicago. The chairman of FMA's Speakers Bureau was the only witness to testify for organized medicine. He utilized research and facts prepared by the FMA staff.

The role of government in medicine was the topic of numerous talks before both legislative and consumer audiences. In facing our problems as a state with an ever-increasing number of elderly citizens, FMA is at times placed in an adversary relationship with government leaders determined to control costs with less than adequate understanding of escalating values. The Speakers Bureau has worked to bring about enlightenment in the areas of controversy while emphasizing medicine's desire for an ever-improved cooperative relationship with government leaders.

SECOND HOUSE OF DELEGATES

The members of the Speakers Bureau express appreciation for the past efforts of all who have participated in this vital program and solicits the entire membership's energetic activities in telling organized medicine's story to an ever-widening public audience. It is the public to whom we must look for continuance and as effective allies.

The Reference Committee moved to amend the Report of the Florida Medical Foundation, in the section on "Committee on Impaired Physicians," the third paragraph, by deleting the words "The Foundation is proud to report that" so that it reads, "Several physicians are now in treatment through this important program." The amendment carried.

The Report of the Florida Medical Foundation, with the exception of those items referred to other Reference Committees was adopted as amended.

Florida Medical Foundation

Eugene G. Peek Jr., M.D., President

The Florida Medical Foundation continues to play a major role in Florida Medicine through its many and varied activities. Members of the Board of Directors of the Foundation met regularly in conjunction with meetings of the Florida Medical Association Board of Governors. The major activities that commanded the Foundation's attention are summarized below:

Peer Medical Utilization Review (PMUR)

Peer Medical Utilization Review continues to be one of the major activities of the Florida Medical Foundation. This year PMUR activities were expanded when the Foundation entered into contracts with the Florida Medicaid Program and the Division of Workers' Compensation. A brief suspension of PMUR activities for the Medicare Program was experienced during a period in which contract negotiations were conducted. However, final agreement was reached with Blue Cross and Blue Shield of Florida, Inc., to do Peer Medical Utilization Review for the Medicare Program in all Florida Counties with the exception of Dade and Monroe Counties.

The overall objective of the Committee on PMUR this year was to strive to improve understanding about PMUR insuring consistency and equity in the peer review process. As has been the custom since the PMUR Program began, representatives from county medical societies were invited to each meeting of the PMUR Committee, and staff communicated with county medical society staff on a regular basis to assure continuity and continuing dialogue.

The PMUR Program continues to be one of the most meaningful efforts undertaken by the Foundation since the Program began in 1972.

Committee on Impaired Physicians

Under the expert guidance of Chairman Guy T. Selander, M.D., of Jacksonville, the Florida Medical Foundation Committee on Impaired Physicians Program has succeeded in implementing a statewide Impaired Physician Program consistent with policy adopted by the 1980 Florida Medical Association House of Delegates.

Since last summer when the Committee was created, it has retained a part-time medical director, installed a hot line for reporting impaired physicians and has presented two major statewide conferences, one of them for intervention training.



FMA Secretary Robert E. Windom, M.D. (left) and President T. Byron Thames, M.D., discuss some business before the House of Delegates while FMA Executive Vice President W. Harold Parham, D.H.A., follows the proceedings in his handbook.

Several physicians are now in treatment through this important program. Solicitation among Florida Medical Association members and Auxiliary members for voluntary tax deductible contributions support the program.

The Committee on Impaired Physicians has proposed a more detailed report of its activities which will be available to the Board of Governors and House of Delegates.

Committee on Medical Education

The Committee on Medical Education ably chaired by Robert H. Threlkel, M.D., of Jacksonville, has continued its effective work in providing quality continuing medical education opportunities for Florida physicians. During calendar year 1980, it serviced thirty applications for accredited co-sponsorship by the Foundation, resulting in designation of 395 hours of AMA Category I Credit, with action on 59 hours pending.

During January and February of 1981, CME providers filed eight applications for Foundation co-sponsorship seeking a total of 108 Category I hours.

Medical Student Loans

The Foundation continues to have a Student Loan Program administered through the Florida First National Bank of Jacksonville with the Foundation serving as the guarantor. A moratorium still exists on the program until sufficient loans have been repaid to remove the threat of the solvency of the Program. Since the last Annual Report, the number of in-school loans has been reduced from fifteen (15) loans with a loan balance of \$41,674.38 to eleven (11) with a loan balance of \$30,334.80. There are sixty-five (65) loans in repayment status which total \$89,302.96. The Foundation as guarantor has paid five (5) loans totaling \$5,718. The Foundation is actively pursuing the collection of these defaulted loans.

Nutrition Textbook

The Special Nutrition Issue of *The Journal of the Florida Medical Association, Inc.*, published in April, 1979, received such acclaim

nationwide that it is being published in textbook form. Four new chapters were added along with a foreword and the references updated. The book is currently being published and should be available for sale in April, 1981. Royalties from this book will be shared equally by Florida's three medical schools who participated in this joint venture with the Foundation.

AMA Jail Project

In 1979, the Foundation entered into an agreement with the American Medical Association for Florida's participation in the AMA Jail Project which is a national program to improve medical care and health services in local jails. The FMA's Council on Medical Services has served as an advisory committee for the Program in Florida. Over the past two years, the Foundation has provided technical assistance for implementing AMA standards to twelve county jails:

Alachua Corrections Center	Orange Correctional Facilities
Gadsden Jail	Palm Beach Jail
Highlands Jail	Pinellas Jail
Hillsborough	Sarasota Jail
Marion Jail	Seminole Correctional Facility
Monroe Jail	Wakulla Jail Facility

All of these jails have demonstrated significant progress in upgrading health care services. One jail (Orange County) has received a full two-year accreditation from the AMA and three other jails are very close to this goal.

In April 1981, the technical assistance part of the AMA Jail Project will be discontinued because of the elimination of federal funding. Nevertheless, the AMA will continue the accreditation program for any interested jail.

Florida Medical Association Auxiliary

A very special note of appreciation is expressed to the Florida Medical Association Auxiliary, for their many fund raising projects on behalf of the Florida Medical Foundation.

Ad Hoc Committee on Impaired Physicians

The Report of the Committee on Impaired Physicians was adopted.

Ad Hoc Committee on Impaired Physicians

Guy T. Selander, M.D., Chairman

In 1980, the House of Delegates, acting on the final report of the previous Ad Hoc Committee on Impaired Physicians, directed "that the Florida Medical Association establish, finance and undertake to implement a statewide impaired physicians program for physicians whose use of alcohol or other chemical substances may interfere with their ability to practice medicine."

The House also ordered a "structured program that will be supportive, rehabilitative, non-punitive."

Your Committee is proud to report that with the active encouragement and support of the FMA Board of Governors and the FMF Board of Directors, the intent of the House of Delegates has been complied with.

Recommendation No. 3 of the previous Ad Hoc Committee, also adopted by the House, called for a systematic program with four phases. Progress and action in each phase is summarized as follows:



FMA President and Mrs. T. Byron Thames, M.D.

"The establishment of a standing permanent statewide committee with broad background and broad geographic distribution with FMA Auxiliary representation."

Action: A Committee on Impaired Physicians (which makes the present report) was set up within the Florida Medical Foundation. There is broad representation with the Panhandle, Upper East Coast, Lower East Coast and Central Florida represented. Mrs. Marybeth Weigand of Deltona was appointed as the Auxiliary representative on the Committee.

"The FMA employ a medical director with expertise in the field of alcoholism or an addictionologist and that he can be hired as a full-time or part-time employee."

Action: The Board of Governors, in June, directed that the position be parttime. The Committee on Impaired Physicians had to look no further than its own membership to find a qualified individual to assume the position on a part-time, acting basis. The Committee's nomination of Dolores A. Morgan, M.D., Director of South Miami Hospital's excellent alcohol treatment center, was confirmed by the FMA Executive Committee in November.

"Establishment of a 'hot telephone line' with supporting clerical staff and a published address to receive calls and information regarding impaired physicians."

Action: Early this year, the "hot line" was installed, terminating in the Medical Director's office. Calls on this line will be answered by Dr. Morgan. During her periods of absence from the office, the line will be plugged into an answering system that will record messages. The "hot line" number — (305) 667-8717 — has been publicized in *The Journal of the Florida Medical Association*, other FMA publications, outside publications, and on an envelope stuffer that was included in the issue of *FMA Briefs* that was mailed in February.

"After the above steps have begun, the committee and director will establish confrontation teams and appropriately educate these teams. The teams will be used to contact the impaired physician and encourage him to seek rehabilitation voluntarily. The committee will also verify compliance."

SECOND HOUSE OF DELEGATES

Certainly, it can be said that the program has been fully implemented, although it is not yet operating at peak capacity and probably will not for several months yet. During the past year, the Committee has been involved with a number of related activities and has had to address several questions, as follows:

1. **Funding:** Through the generosity of the FMA Board of Governors and the FMA Auxiliary, the Impaired Physician Program enjoys adequate funding for this year. In addition, the Board of Governors has authorized a solicitation of FMA and Auxiliary members for additional funds. The solicitation of FMA members was conducted in conjunction with the issue of *FMA Briefs* mailed in mid-February.
2. **Educational Activities:** The Committee recognizes that if the program is to be successful, an on-going educational program must be mounted. This has begun. The Committee's first major statewide education effort was the "Workshop on Impaired Physicians: Paving the Road to Recovery", a two and one-half hour program presented at Lake Buena Vista on January 30, the day before the opening of the annual FMA Leadership Conference. This highly successful meeting was attended by a standing-room-only crowd of more than 100 interested physicians, Auxiliary members, county medical society executives and others. Through this meeting, the Committee identified a number of physicians who are interested in becoming involved at the local level.

The Committee is co-sponsoring, with the FMA, a Section on Chemical Dependency on Friday morning, May 1, during the 107th Annual FMA Meeting. Speakers will include: G. Douglas Talbott, M.D., Director of Georgia's Disabled Doctors Program; David Smith, M.D., Director of the Haight-Asbury Clinic in San Francisco, California; and Drs. Morgan and Selander.

The Committee is looking into the possibility of presenting an educational program for hospital administrators and medical staff chiefs at the 1981 Annual Meeting of the Florida Hospital Association.

Intervention workshops are discussed elsewhere in this report.

Members of the Committee have been called upon to speak on the Impaired Physician Program on several occasions before county medical society, Auxiliary and other audiences.

3. **Audio-Visual and Printed Materials:** In developing the Impaired Physicians Program, the Committee has relied heavily on audio-visual and printed materials produced by other impaired physician programs and other organizations. A print of the 16 mm film "Our Brother's Keeper" has been acquired. The film, dramatizing the fall of a successful physician into the abyss of alcoholism and the impact of all of this upon his family and colleagues, was shown at the January 30 workshop. It is available on a loan basis to county medical societies, Auxiliary units and specialty groups.

The Dade County Medical Association Impaired Physicians Committee has developed an excellent slide presentation. The State Committee plans to modify it for use on a statewide basis.

The National Council on Alcoholism, Kemper Insurance Co., Blue Cross and Blue Shield, and the Center for the Well-Being of Health Professionals in North Carolina are among sources of printed materials used by the Committee.

The Committee's future plans include probable development of printed materials of its own.

4. **Confidentiality:** The matter of confidentiality has been a source of some concern to not only members of the Committee but other

Florida physicians. Of particular concern is Section 458.331(1)(f), Florida Statutes. This section provides a ground for disciplinary action by the Board of Medical Examiners and the Department of Professional Regulation against a licensed physician for "failing to report to the department any person who the licensee knows is in violation of this chapter (the Medical Practice Act) or the rules of the department or the board." This was discussed on January 9 at a meeting of representatives of the Committee with Secretary Nancy K. Wittenberg of the Department of Professional Regulation and members of her staff. She said at that time and later confirmed in a letter that in the view of her Department, this provision of the law would not apply to a physician who is treating another physician for illness or use of drugs or alcohol or as a result of a mental or physical condition, provided the treatment program is appropriate and acceptable.

5. **Medical School Curricula:** The Committee asked the Deans of Florida's three medical schools to include in their academic curricula adequate instruction in the disease aspects of alcoholism and drug addiction. All responses were positive.
6. **Local Assistance:** Formation of local impaired physician committees has been encouraged. Communications have gone out seeking volunteers at the local level to assist the Committee in educational, intervention, rehabilitation and monitoring activities. The help of physicians who themselves have recovered from alcoholism or addiction is particularly sought. The results have been gratifying.
7. **Treatment Programs:** The Committee will not itself operate a treatment program but will refer physicians to existing programs that are appropriate to their individual cases. The Committee is in the process of developing criteria for treatment programs and facilities.
8. **Caseload:** A few Florida physicians already are in various phases of our program. Up-to-date information will be made available to the Reference Committee at the 107th Annual Meeting.

Summary: A statewide impaired physicians program has been established in accordance with the desires of the House of Delegates at the 1980 Annual Meeting, and the FMA Board of Governors at its meeting subsequent to the Annual Meeting. The full moral and financial support of the FMA Auxiliary and the Board of Governors has been a blessing to this program. The Chairman salutes his colleagues on the Committee for their 100% attendance at meetings; and thanks county medical societies and individual physicians for their offers of assistance.

Florida Physicians Association

The Report of the Florida Physicians Association was adopted.

Florida Physicians Association

David T. Overbey, M.D., President

The Florida Physicians Association was founded in December 1972, as a nonprofit corporation designed primarily to protect the private practice of medicine by undertaking activities that the Florida Medical Association could not enter into because of charter restrictions or legal ramifications which if pursued might lead to possible financial damages.

During this past year the Florida Physicians Association has undertaken a program of membership recruitment for the purpose of developing sufficient funds to allow for meaningful involvement in activities which will preserve the professional and economic independence of physicians and protect the patient/physician relationship from



President-Elect Sanford A. Mullen, M.D. (left) and Treasurer J. Russell Forlaw, M.D., follow along as a reference committee chairman presents his report.

governmental and third-party intervention and/or encroachment.

The Florida Physicians Association is currently reviewing the feasibility of: co-sponsoring with the American Medical Association, Department of Negotiation, annual negotiation seminars; monitoring the promulgation of rules and regulations generated by federal and state agencies, and other activities designed to protect the rights and interests of the membership.

Judicial Council

The Report of the Judicial Council, with the exception of the item referred to another Reference Committee was adopted.

Judicial Council

James A. Winslow Jr., M.D., Chairman

The 1981 Annual Report of the Judicial Council will summarize the major areas of activity that occupied the Council's time since the last Annual Meeting of the Florida Medical Association, held in May 1980. The Council's duties, functions, and composition are specifically prescribed in Paragraph 8, Section 3 of the Florida Medical Association Bylaws.

Generally, it is the function of the Judicial Council to direct and supervise the activities of the Association which pertain to questions of medical ethics, dissension, and disputes referred to the Association for investigation and adjudication, complaints by patients against members of the Association, and questions of membership and disciplinary action. A great many of the questions that arise are handled by the Chairman and other members of the Council on a telephone conference basis. The Bylaws of the Florida Medical Association further provide that component county medical societies shall be the basic unit for

censuring, suspending, or otherwise disciplining its members. Any member subject to such action has the right to appeal to the Judicial Council in the manner prescribed in the Bylaws. Since the last Annual Report of your Judicial Council, your Chairman has reported to the Board of Governors up-to-date summations and recommendations relative to major areas of Council concern. Since the last Annual Meeting of the Association, the Council has met on the following occasions: May 7 and October 4, 1980, and January 30, 1981. The current membership of the Council is as follows: James A. Winslow Jr., M.D., Chairman, Tampa, Florida; Vincent P. Corso, M.D., Vice-Chairman, Miami, Florida; Joseph H. Davis, M.D., Miami, Florida; Robert J. Brennan, M.D., Ft. Lauderdale, Florida; and O. Frank Agee, M.D., Gainesville, Florida. The Council has been staffed by Mr. John Thrasher, Associate Executive Director and Legal Counsel for the Florida Medical Association.

The Council's activities are summarized under the appropriate headings as follows:

1. **FMA Policy Statement, Re: Advertising by Members:** Since the adoption of the Florida Medical Association Policy, Re: Advertising by Members at the May 1979 Annual Meeting, the Council has on numerous occasions extensively considered what criteria it ought to utilize in reviewing requests for additions to the endorsed specialty listing section, which is a part of the Policy on Advertising. While the Council does not feel it should be bound by any inflexible guideline, it does feel that individuals who may want to request additions to the endorsed specialty listings in the future ought to have some notice of the broad considerations the Council utilizes when considering these requests for additions to the endorsed listings. These criteria include, but are not limited to the following:

- a. does the requested listing serve a need to the public;
- b. is the requested listing redundant with other specialties that are already approved and endorsed;
- c. is the requested listing a bona fide aspect of medical practice;
- d. does the requested listing have board certification recognition; and
- e. does the requested listing describe what the physician does.

During 1980 the Council considered a request for the addition of "Emergency Medicine" to the list of approved specialties and upon consideration of such, added Emergency Medicine to the approved list during its October 1980 meeting.

It is the continuing belief of the Judicial Council that physicians on an individual basis have continued to recognize their personal responsibility in the area of advertising and have sought to maintain the highest degree of professionalism notwithstanding a more liberalized approach in this area brought on by anti-trust and court considerations.

2. **Grievances:** The Council has, pursuant to the Bylaws of the Florida Medical Association, responsibility for reviewing decisions of county medical societies wherein one of the parties requests an appeal. This system has worked efficiently and the Council encourages each county society to process and finalize decisions on grievances in an efficient, fair and expeditious manner. During the past year the Council's Membership and Discipline Committee was activated on one occasion and provided a recommendation and report to the Council in reference to an appeal by a physician from a decision of a county medical society. While Membership and Discipline Committees in the past several years have been rarely used, they continue to be an important aspect of the Association's mechanism for resolving internal problems between physicians and their county medical societies.

SECOND HOUSE OF DELEGATES

During the course of the year questions have arisen relative to the fundamental aspects of procedural due process in handling grievances involving physician members. In reviewing most of these questions, it has been determined that generally speaking, county medical society bylaws contain the necessary provisions to afford procedural due process to an individual accused of unethical conduct. It is essential that the county medical society not disregard the procedural safeguards enacted in their Bylaws and/or Charter. Several basic criteria for procedural process are outlined as follows:

- a. the charged member should be informed in writing of the statement of charges to which he or she is being asked to respond;
- b. the charged member should be given notice of the time and place of a proposed meeting to review the charges;
- c. the charged member should be afforded the opportunity to appear in person before the appropriate committee and defend against the charges.

3. **Review of County Medical Society Revisions to Charter and Bylaws:** Pursuant to the Bylaws of the Florida Medical Association the Bylaws of component medical societies must not be in conflict with those of the FMA. The Council, during the past year, has continued to review revisions and amendments to County Medical Society Charter and Bylaws and encourages County Medical Societies to timely submit those proposed changes to the Judicial Council for their review.
4. **Opinions of The Judicial Council:** During the past year the Council rendered or adopted the following opinions:

Opinion 80-1: An arrangement whereby a physician leasing from a medical clinic group is supplied with equipment, treatment rooms, clerical personnel for billing and accounting and para-professional staff support and where the medical clinic in return for these services receives an agreed percentage of the leasing physician's professional fees, is considered by the Council to be an unethical arrangement.

Opinion 81-2: A physician using a medical laboratory should charge the patient exactly what the laboratory charges the physician; provided, the physician may charge in addition to the above, a reasonable charge for acquisition of the sample and a reasonable handling charge. (Ref. to Bd. of Gov. by Refer. Comm. No. V)

5. **Vincent P. Corso, M.D.:** The Council regrets to acknowledge the impending departure from the membership of the Council of Vincent P. Corso, M.D. Dr. Corso will complete his second five year term as a member of the Council during the May 1981 meeting. The Bylaws of the Florida Medical Association provide that no member may serve on the Judicial Council for more than two consecutive five year terms. Dr. Corso's contributions to the Judicial Council have been enormous. His quiet but effective manner has contributed immeasurably to leading the Judicial Council through numerous difficult problems that it has encountered over the last ten years. During the last two years of his ten years of the Council, Dr. Corso has served as State Grievance Chairman and handled the multitude of grievances that come to him in a fair and impartial manner, providing the Council with great insight into the disposition of these grievances. Dr. Corso's highly professional manner, his astute insight and judgement will be greatly missed by the Judicial Council. The Council, on behalf of all members of the Florida Medical Association, wishes to extend its appreciation and gratitude for his service on this most important Council of the Florida Medical Association.

RESOLUTION 81-2 Bylaws Amendment

Escambia County Medical Society

Resolution 81-2 was not adopted.

RESOLUTION 81-6 Dues Reduction for Semi-Retired Physicians Duval County Medical Society

The Reference Committee feels that the necessary mechanism already exists whereby county medical societies may reduce fees, and application may be made to the Florida Medical Association for hardship status. It was also pointed out that no hardship case has ever been refused by the Board of Governors.

Resolution 81-6 was not adopted.

RESOLUTION 81-7 Special Licensing for Physician Educators and Public Health Physicians Pasco County Medical Society

Resolution 81-7 was not adopted.

RESOLUTION 81-9 Installment Payment of Dues Broward County Medical Society

The motion of the Reference Committee that Resolution 81-9 be referred to the Board of Governors carried.

RESOLUTION 81-9 Installment Payment of Dues [Not Adopted — Referred to the Board of Governors]

Whereas, With the ever-increasing costs and the resulting inflation, it is inevitable that dues will increase at county, state and national levels, and

Whereas, Most organizational dues are due and payable on January 1, along with other financial responsibilities, therefore be it

RESOLVED, That a study be made of the possibility of installment payment of dues throughout the year.

RESOLUTION 81-11 Seating of Delegates

Hillsborough County Medical Association

The Reference Committee recommended that Resolution 81-11 not be adopted.

A substitute motion from the floor to refer Resolution 81-11 to the Board of Governors failed to carry.

The main motion on the floor was again Resolution 81-11 itself, the motion carried, and Resolution 81-11 was adopted.

REFERENCE COMMITTEE NO. III

RESOLUTION 81-11

Seating of Delegates

Hillsborough County Medical Association

RESOLVED, The Board of Governors of the Florida Medical Association be directed to prepare amendments to the Bylaws, patterned after those of the American Medical Association Bylaws and Rules of the House of Delegates, to provide for the flexible interchange of Delegates and Alternates to participate in the meetings and sessions of the House of Delegates with full privileges; and be it further

RESOLVED, That these amendments to the Bylaws be mailed to each delegate and alternate with the House of Delegates Handbook at least thirty days prior to the Annual Meeting in May 1982.

RESOLUTION 81-13

Health Systems Agency Monitoring

Dade County Medical Association

The Reference Committee sympathized with the intent of this Resolution but felt it should not be adopted as presented.

Resolution 81-13 was not adopted.

RESOLUTION 81-14

Florida Medical Association's Defense of a Lawsuit Against Various Insurance Intermediaries

Dade County Medical Association

The Reference Committee moved that Resolution 81-14 be referred to the Board of Governors, with the request that it reconsider its decision, as reported in its Report A to this House, concerning participation in the lawsuit referred to in this resolution. The motion carried, and Resolution 81-14 was referred to the Board of Governors.

RESOLUTION 81-14

Florida Medical Association's Defense of a Lawsuit Against Various Insurance Intermediaries

[Not Adopted — Referred to the Board of Governors]

Whereas, The Dade County Society of Internal Medicine has filed a lawsuit against various insurance intermediaries regarding the application of specialty screens in Florida; and,

Whereas, The FMA Board of Governors has directed the FMA to participate in the defense of this lawsuit filed by several hundred FMA

members; and,

Whereas, FMA's involvement in this lawsuit supporting the FMA House of Delegates opposition to specialty screens could initiate a potential internecine conflict among the members of the Florida Medical Association; and,

Whereas, It is highly irregular and inappropriate for the FMA to participate in the defense of intermediaries against fellow FMA members; therefore be it

RESOLVED, That the FMA utilize every available means to refrain from defending the lawsuit filed by the Dade County Society of Internal Medicine against various insurance intermediaries; and be it further

RESOLVED, That FMA refrain from spending Association's funds, which are largely received from members, in defense of this lawsuit.

RESOLUTION 81-18

Nominations for FMA Elected Offices

Dade County Medical Association

Upon recommendation of the Reference Committee Resolution 81-18 was not adopted.

RESOLUTION 81-19

Location — Annual Meeting of the FMA House of Delegates

Alachua County Medical Society

Upon recommendation of the Reference Committee, Resolution 81-19 was not adopted.

The Chairman expressed his thanks to each member of the Reference Committee and to Dr. Rufus K. Broadaway for their diligent attention to the business of the House of Delegates. Thanks was conveyed to Mrs. Bonnie Todd, Recording Secretary, Ms. Wanda McWaters and other FMA staff members for their support of the Committee and many members of the Association who attended the meeting and presented testimony.

The motion of the Reference Committee that the Report of Reference Committee No. III as a whole be adopted as amended carried.

The House recessed at 5:30 p.m. to reconvene at 9:00 on Sunday morning, May 3.

Third House of Delegates

The third meeting of the House of Delegates convened at 9:00 a.m. on Sunday, May 3, 1981, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with the Speaker of the House, Dr. James B. Perry, presiding.

Dr. Reginald J. Stambaugh, Chairman of the Credentials Committee, reported 233 Delegates were registered, representing 38 county societies, which constituted a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; William B. Deal, M.D.; William T. Hawkins, M.D.; Douglas O. Jenkins, M.D.; Edward R. Woodward, M.D.; Diane M. Zabak, Student Delegate

BAY — William G. Bruce, M.D.; Philip Cotton, M.D.

BREVARD — Richard N. Baney, M.D.; Walter J. Cerrato, M.D.; Michael J. Foley, M.D.; Brian P. Gibbons, M.D.; Francis S. Pooser, M.D.; Robert J. Sarnowski, M.D.

BROWARD—Charles H. Bechert II, M.D.; Robert L. Berger, M.D.; Anna M. Blenke, M.D.; Robert J. Brennan, M.D.; Andre S. Capi, M.D.; Philip A. Caruso, M.D.; David A. d'Alessandro, M.D.; Burns A. Dobbins, M.D.; Arthur L. Eberly, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; William C. Hartley, M.D.; George P. Messenger, M.D.; Jerry D. Moore, M.D.; Thomas F. Regan, M.D.; William Richman, M.D.; Richard D. Shafron, M.D.; N. W. Skaja, M.D.; Anthony J. Vento, M.D.; Harry B. Weinberg, M.D.; Juan S. Wester, M.D. (Absent — Joseph A. Benenati, M.D.; Robert C. Bishop, M.D.; David C. Lane, M.D.; Orlando Maytin, M.D.; Herbert M. Todd, M.D.; Peter A. Tomasello, M.D.)

CAPITAL — Merton L. Ekwall, M.D.; Robert P. Johnson, M.D.; M.D.; Nelson H. Kraeft, M.D.; Robert N. Webster, M.D.; George N. Lewis, M.D.

CHARLOTTE — Thomas Cititella, M.D.; Joseph R. Goggin, M.D.; Jaime Torner, M.D.

CITRUS-HERNANDO — W. Randall Jenkins, M.D.; Clinton J. McGrew, M.D.

CLAY — Hinson L. Stephens, M.D.

COLLIER — Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.; Allen S. Weiss, M.D.

COLUMBIA — Jose Goyenechea, M.D.

DADE — Joseph Allison, M.D.; Edward R. Annis, M.D.; Jerome Benson, M.D.; Jose S. Bocles, M.D.; Robert E. Boyett, M.D.; Rufus K. Broadaway, M.D.; Edmund Cava, M.D.; Manuel L. Carbonell, M.D.; Richard C. Clay, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Augusto Fernandez-Conde, M.D.; Miguel Figueroa,

M.D.; N. Ralph Frankel, M.D.; George R. Gage, M.D.; Julian H. Groff, M.D.; Joseph Harris, M.D.; Walter C. Jones III, M.D.; Herbert S. Kaiser, M.D.; Norman M. Kenyon, M.D.; Maurice H. Laszlo, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Roberto L. Maury, M.D.; Charles A. Monnin, M.D.; Miguel A. Mora, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; William E. Riemer, M.D.; Walter W. Sackett, M.D.; Oscar Sandoval, M.D.; Daniel Seckinger, M.D.; Everett Shockett, M.D.; M. David Sims, M.D.; Margaret C. S. Skinner, M.D.; Douglas Slavin, M.D.; Leonard S. Sommer, M.D.; Chauncey M. Stone, M.D.; Charles F. Tate Jr., M.D.; John C. Turner, M.D.; Thomas B. Turner, M.D.; Emilio A. Trujillio, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Elliot Witkind, M.D.; Edmund K. Zahn, M.D.; Sheldon Zane, M.D.; Jim Deming, Student Delegate (Absent — Jack Q. Cleveland, M.D.; James D. Hanson, M.D.; Norman Korman, M.D.; Arthur Radin, M.D.; Steven M. Weissberg, M.D.)

DESOTO-HARDEE-GLADES — Calvin W. Martin, M.D.

DUVAL — Gaston J. Acosta-Rua, M.D.; Harvey E. Bernhardt, M.D.; William P. Booras, M.D.; James L. Borland, M.D.; Yank D. Coble Jr., M.D.; Patricia C. Cowdery, M.D.; Wilbert L. Dawkins, M.D.; Richard C. Dever, M.D.; Emmet F. Ferguson Jr., M.D.; Charles P. Hayes Jr., M.D.; Charles W. Lewis Jr., M.D.; John F. Lovejoy, M.D.; Charles B. McIntosh, M.D.; Faris S. Monsour Jr., M.D.; Daniel B. Nunn, M.D.; Guy T. Selander, M.D.; George S. Trotter, M.D.; James W. Walker, M.D.

ESCAMBIA — Paul T. Baroco, M.D.; Rae W. Froelich, M.D.; Eric F. Geiger, M.D.; Charles J. Kahn, M.D.; Theodore J. Marshall, M.D. (Absent — C. Fenner McConnell, M.D.)

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — Joseph P. Hendrix, M.D.

HIGHLANDS — Vinod C. Thakkar, M.D. (Absent — Robert T. Rengarts, M.D.)

HILLSBOROUGH — Richard A. Bagby, M.D.; Francis C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Robert G. Isbell, M.D.; Thomas E. McKell, M.D.; John K. Petrakis, M.D.; J. Robert Qualey, M.D.; Ralph E. Rydell, M.D.; Ronald L. Seeley, M.D.; William W. Trice, M.D.; Harold L. Williamson, M.D.; James A. Winslow Jr., M.D.; Donald Lofland, Student Delegate (Absent — Ralph M. Stephan, M.D.)

INDIAN RIVER—(Absent—Donald L. Ames, M.D.; Kip Kelso, M.D.)

LAKE—Frederick C. Andrews, M.D.; Robert H. Hux, M.D.

LEE—Cecil C. Beehler, M.D.; Larry P. Garrett, M.D.; John S. Hagen,

M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.

MADISON — no delegate submitted

MANATEE — Thomas R. Busard, M.D.; Julian Giraldo, M.D.; Roger

A. Meyer, M.D.; Michael G. Ryan, M.D.

MARION — C. Brooks Henderson, M.D.; James L. McLaughlin, M.D.;

Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D. (Absent — Robert O. Baratta, M.D.)

MONROE — Robert Carraway, M.D.; Ronald H. Chase, M.D.

NASSAU — (Absent — Jose L. Castillo, M.D.)

THIRD HOUSE OF DELEGATES

OKALOOSA — David R. Arrowsmith, M.D.; Samuel M. Atkinson Jr., M.D.
ORANGE — Edward Ackerman, M.D.; Clarence H. Brown III, M.D.; Manuel J. Coto, M.D.; Clarence M. Gilbert, M.D.; Alberto J. Herran, M.D.; David L. Mackey, M.D.; Joseph G. Matthews, M.D.; Hector R. Mendez, M.D.; James F. Richards Jr., M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D.; Robert B. Trumbo, M.D.; Cecil B. Wilson, M.D. (Absent — James J. Schoeck, M.D.)
OSCEOLA — Gilberto Perez, M.D.
PALM BEACH — Vernon B. Astler, M.D.; Richard C. Cavanagh, M.D.; John D. Corbitt Jr., M.D.; Jerry F. Cox, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V.A. Marks, M.D.; R. Benjamin Moore, M.D.; Reginald J. Stambaugh, M.D.; Ben R. Thebaut Jr., M.D.; Dick L. Van Eldik, M.D.
PANHANDLE — Herbert E. Brooks, M.D.; K. Sinclair Franz, M.D.
PASCO — David A. Johnson, M.D.; Robert D. May, M.D.
PINELLAS — William W. Atkinson, M.D.; Thomas M. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay Knight Hanley, M.D.; Harold L. Ishler Jr., M.D.; Morris J. LeVine, M.D.; Jack A. MacCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Bruce P. Smith, M.D.; Walter H. Winchester, M.D. (Absent—Michael H. Diamond, M.D.; Davis S. Hubbell, M.D.)
POLK — Thomas M. Caswall, M.D.; John W. Glotfelty, M.D.; Stanley W. Lipinski, M.D.; Thomas E. McMicken, M.D.; John C. Moore Jr., M.D.; David Stoler, M.D.; Paul A. Tanner Jr., M.D. (Absent — Wiley E. Koon, M.D.)
PUTNAM — Anne Beynitzky, M.D.
ST. LUCIE-OKEECHOBEE — Charles R. Cambron, M.D.; William H. Meyer Jr., M.D.
SANTA ROSA — David B. Young, M.D.
SARASOTA — John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Keihl, M.D.; Martin F. Mihm, M.D.; Franklin H. Pheiffenberger, M.D.; Karl R. Rolis, M.D. (Absent — Richard C. Rehmer, M.D.)
SEMINOLE — Luis M. Perez, M.D.; Frederick J. Weigand, M.D.
SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Andrew C. Bass, M.D.)
TAYLOR — (Absent — John H. Parker, M.D.)
VOLUSIA — Grandy B. Barnard, M.D.; Charles R. DeArmas, M.D.; William R. Jones, M.D.; Remigio G. Lacsamana, M.D.; Alvin E. Smith, M.D.; Richard W. Snodgrass, M.D.
WALTON — (Absent — Howard F. Currie, M.D.)
WASHINGTON — (Absent — Muhannad Amin, M.D.)
SPEAKER OF THE HOUSE — James B. Perry, M.D.
VICE SPEAKER — Franklin B. McKechnie, M.D.

Dr. Perry suggested that, if feasible next year the Second House would convene earlier in the day in order that the business of the House could be finished possibly by the end of the day on Saturday. This met with the unanimous approval of the House.

The Speaker recognized distinguished guests — Joe and Madeline Lang from Dr. Thames' office and Joyce Kerr, also from Dr. Thames' office.

Installation of the President

Dr. Perry recognized the President, Dr. T. Byron Thames, and asked that he come forward to install the

new President.

Dr. Thames then presented the personal gavel and President's certificate to Dr. Sanford A. Mullen, the new President.

Dr. Mullen presented Dr. Thames with the Past President's Pin and asked Dr. Murray and Dr. Mendez to escort Mrs. Pat Thames to the platform, where he presented her with Dr. Thames' portrait.

Remarks of the President

It's my privilege to make a few comments to you now concerning the ideas that I have for the year ahead.

First of all, I think the most difficult thing I'll face in the year ahead is the opportunity of following Byron Thames and his leadership. That inspires me to do my very best, and I know Byron will be helping me along with the Board and, I am sure, all of you. There is an individual who has put up with my activities in this organization and in other organizations for now a little over 35 years, my very charming bride, Minnie.

I'm very sorry our three sons are not here but one is busy in his residency, and I'm proud to say in pathology. One son is supposed to be in college and I suspect that he is. And the other son is supposed to be building houses — and you know the problems that those people have these days — so he couldn't get down here but maybe next year we'll have that opportunity for the "terrible trio" to come along with us. At least we are going to try to twist their arms to do so.

You know, I feel so much a part of this House. It's been now 17 years that I have participated as a delegate and more recently as your Vice Speaker and Speaker, and now the culmination of all my hopes and aspirations to be given the opportunity and the challenge to be your leader.

It is to me indeed a most awesome and challenging opportunity, and whenever I get fearful of the things that lie ahead I become more comfortable when I look back and know that the Board of Governors is with me; the Council and Committee chairmen and members and this House of Delegates, the Auxiliary, and all of us are together. The over 13,000 members of the Florida Medical Association are together as a unit. This awesome force for good for both the citizens of Florida and the doctors of Florida is to me reassuring as I go forward into this year.

One of the most important things to me is reflected in the theme that I have chosen during my year as President. The theme is, "Community Service by Physicians." I think that it is absolutely essential for all of us to recognize that we have a great responsibility to our communi-



Retiring President T. Byron Thames, M.D. (left), presents the presidential gavel and certificate to his successor, Sanford A. Mullen, M.D. (right picture). In right photo, Dr. Mullen affixes the Past President's pin to Dr. Thames' lapel.



ties. The prototype — the epitome — of this service to our communities is exemplified in the life and activities of Abel Baldwin, our founding President and the one whom we honor with the Baldwin Lecture each year.

Dr. Baldwin was a practicing physician in Jacksonville before the turn of the century. He dealt with yellow fever and malaria outbreaks and epidemics and many other things that we know of only in a historical sense these days. He was first a physician, but he was second an involved citizen in the community. He served as a representative and later as a senator representing Duval County in the State Legislature, and I'll remind you that this was not an easy time during the reconstruction of the South following the war between the states. But Dr. Baldwin worked hard; he didn't succeed in everything that he tried, but he never gave up trying.

I call on you to become involved—you and your colleagues throughout the State — in those worthwhile community activities that are so necessary for our communities to improve the way that we would want them for our children and their children in subsequent generations.

Sometimes I think we feel that by having gone through medical school, completed our specialty training and hanging out the shingle, that all we have to do from that time on is practice medicine. I really think nothing could be farther from the truth. I think that first of all we have to be good in our profession; we have to keep up with all of the modern advances in medicine. Certainly, we must never let that become less than our primary goal. In our role as citizens our responsibility is the stew-

ardship of the health and medical well-being of our communities.

But beyond that, we must become involved more and more throughout the community in whatever our area of action is, be it church, fraternal organization, youth work or whatever. Be involved!

There should be no important decisions made in your community without input by physicians at the beginning of the decision-making process. It's awfully important for us to be involved so that we can permeate through the entire structure of our communities much as the leavening in bread and so that we're everywhere and yet we're not identified. We're ambient through the whole community.

I think that is absolutely essential for us to do. It all fits in with some of the most important challenges that we face in the year ahead.

All of these activities include the support of the Auxiliary. This Auxiliary is so important to everything we do, be it work with the youth, medical education, or the impaired physician. Throughout our other activities the Auxiliary must go hand-in-hand with us. They are a source of great strength, and it is absolutely essential for us to become more involved with them and to see that they are fully a part of our medical activities.

One thing I think you should be aware of if you have not already heard is the need for involvement in the American Medical Association. It is absolutely essential for all physicians who are members of the FMA to become AMA members. Last year we could have had an

additional delegate to the AMA if we had had 35 more members of the FMA who had joined the AMA. We are going to make every effort by the end of this year to see that that does not recur and we have ways of checking it in advance we were not aware of last year. We hope we will be able to add another delegate to the AMA. That way we can have more influence in our national organization.

Doctors are a small group but it is only by working together and going through the community that we can do the necessary activities and achieve the necessary goals of quality medical care for everyone at the most reasonable cost possible. We need to do many things to assure that.

We have a very active year planned in the area of health care financing. That is our new council that you approved by your action yesterday. This Council is going to, among other things, become involved with the help of the officers in business relationships. We are going to call a committee of that Council, the Committee on Business and Industry Relations. We hope to build bridges of friendship with the business community.

Somewhere around 10 per cent depending on the figures that you can find — about 10 per cent of our gross national product is spent for health care in an all-embracing concept. That's a lot of money for the nation, and we have a great responsibility in seeing that business understands the proper allocation of those funds and that only doctors can determine necessary and appropriate medical care. We must not let that be done by the bureaucrats. Our efforts must also include an effort at the very highest level to contain the charges of medical care. We are going to call our committee "Cost Effectiveness." We cannot always contain costs but we can make them effective.

We have to deal with the changing federal government and with the changes that we see coming down the line on HSA's, PSRO's, HMO's — all of these myriad activities are going to be changed dramatically. We want to do our best to be sure that physicians from this Association determine health planning, determine peer review and all of the related activities of the doctors and the patients of the State of Florida.

You see, it really all fits together with involvement in the community. You profit most who serve best — that's a paraphrase of an expression from Rotary that I think can be used here. By our service to the community we really have profits from it. There is more to it than pure altruism. I think that we can do a great deal to enhance the image and the ability of doctors to lead the communities by these activities.

Lest any of you think that the area of professional liability is a settled issue, let me caution you it is far from it. I think that Dr. Astler's comments yesterday set many



Newly-installed FMA President Sanford A. Mullen, M.D., Jacksonville, presents the official portrait of his immediate predecessor, T. Byron Thames, M.D., to Mrs. Thames.

of us thinking. When I realize now that an orthopedic surgeon in New York is going to be paying \$49,500 for his professional liability insurance I say that doesn't sound very good to put it mildly. And we have got to do something to deal with that. We are going to have a special committee of the Board to look at the professional liability problem and to see if we can come to some conclusions as to how to face it in the future.

So you see, we have a very strong and vibrant Florida Medical Association, but it is only as strong and vibrant as you ladies and gentlemen make it. You the doctors and you the Auxiliaries of Florida need to come together, permeate through the community and with all of us working together I am sure that we can do much to turn the tide that has seemed to be running against us in recent years.

I am going to do my best, and as I told you at this podium one year ago, paraphrasing an epitaph on a tombstone out in Tombstone, Arizona, when they said this fellow had died and gave his date of birth and death, and they said:

"He done his damndest"

That was my pledge a year ago and that's my pledge to you today. I am going to keep that up for this year and with all of your help, we'll do the job.

Thank you so much, and let's get going!

The Speaker resumed the Chair and called for the report of Reference Committee No. IV.

Report of Reference Committee No. IV

Legislation and Miscellaneous

Dr. Arthur L. Eberly, Chairman, and his Committee came forward to present the report of Reference Committee No. IV — Legislation and Miscellaneous.

The Reference Committee considered the items referred to it and heard testimony from members of the Florida Medical Association about them. The information given to the Committee by Mrs. Nancy Moreau, Legislative Analyst of the FMA Capital Office, was particularly helpful and enlightening.

The Reference Committee expressed public commendation to Dr. Murray for his outstanding work in his role as Chairman of the Council on Legislation and also expressed their wish to give proper recognition and to commend Mr. Donald S. Fraser Jr., Director of Legislative Affairs, Mr. George S. Palmer Jr., Manager of the FMA Capital Office, Mr. Jim McCloy, Director of Government Programs, and to all other FMA staff members who worked on the legislative program. The Reference Committee also wished to recognize the contributions of all members of the Florida Medical Association who

had participated in FMA legislative activities during the past year.

Report D of the Board of Governors

Report D of the Board of Governors was adopted; however, after some discussion, a motion to reconsider the previous action carried.

A motion was made to amend Report D of the Board of Governors by deleting, in the "Approved for 'endorse'" section, the item regarding temporary licensure of public health physicians. The motion carried.

Report D of the Board of Governors was adopted as amended.

Report D of the Board of Governors



Arthur L. Eberly, M.D., Lighthouse Point (standing), presided over Reference Committee IV (Legislation and Miscellaneous). Left to right: John C. Fletcher, M.D., Tampa; Alvin E. Smith, M.D., Ormond Beach; Ms. Kaye Clark, Recorder; Dr. Eberly;

John M. Hamilton, M.D., St. Petersburg; Charles A. Dunn, M.D., Miami; and Kenneth C. Kiehl, M.D., Sarasota (Alternate Member).

T. Byron Thames, M.D., Chairman

FMA Councils and Committees

COUNCIL ON LEGISLATION

1980 Legislative Session — The Board commended the members of the Council on Legislation and all those who participated in the 1980 legislative program for their significant contributions to success of all major legislative objectives. Special commendation was extended to Dr. Frank Coleman who served as chairman of the Council during the Session and also to state legislation committee chairman Dr. David Lane. The Board also wishes to express appreciation to the many FMA members who served as Doctor of the Day during the Session. This program has been of great benefit to the legislators who may require medical assistance and to the physicians serving as doctor of the day to gain a better understanding of the legislative process.

Passage of the Association sponsored Recovery of Cost Legislation was a major achievement and required a major commitment of FMA resources and staff as well as countless hours of effort by many physicians and other individuals.

A summary of the accomplishments during the 1980 Session is included in the annual report of the Council on Legislation.

1981 Legislative Priorities — Key issues to be addressed during the 1981 Session which have been finalized to date by the Board include:

The Board approved the category of "sponsor" for amendments to the Medical Practice Act that would provide for:

- A. Guidelines for development and approval of protocols with Advanced Registered Nurse Practitioners to include filing of approved protocols with the State Board of Medical Examiners.
- B. Criteria for physician supervision for ARNP's operating in accordance with such protocols.
- C. Restriction to a maximum of two the number of ARNP's that one physician can supervise.
- D. Requirement that a physician must practice in the same community as the ARNP supervised.

Approved a position of "endorse" for:

- Increased funding for county health units in the amount of \$10,900,000.
- Increased funding in the amount of \$30,500,000 for physician services in Medicaid.
- Increased funding for salaries of state-employed physicians.
- Amendments to school health physical law to allow schools to carry out examination and screening unless parent requests exemption. (SB 178, HB 197).
- Changes to Department of Professional Regulation Statute relating to selection of investigators, approval of budgets by Board, and handling of complaints.

Adopted a position of "opposition" to legislation that would provide for:

- Subsidy for state employees enrolling in HMO's.
- Rewrite of Physical Therapy Act which includes a redefinition of "Physical Therapy" and elimination of requirement for physician's prescription for services.
- Mandated use of problem-oriented medical records (SB 106).
- Elimination of current criteria for issuance of temporary and limited medical licenses (SB 182).
- State takeover of county health units and development of primary care programs in county health units (SB 162).
- Authorization for optometrists to use and prescribe drugs.



William M. Straight, M.D., of Miami, *The Journal's* Historical Editor, and Mrs. E. Charlton Prather of Tallahassee, whose husband is an Associate Editor, flash their best smiles for the camera.

- Licensure of Homeopathic physicians (HB 49).
- Hospital privileges for chiropractors (HB 242).
- Funding for HSA's and the SHCC.
- Expansion of Wrongful Death Act (SB 150, HB 104).
- Freedom of choice in selection of physicians.
- School of Chiropractic.

Adopted a position of "disapprove" of legislation for:

- Funding for School of Optometry.
- Licensure of lay midwives.
- Itemized billing for hospital services (SB 186).
- Mandate for HMO's to include chiropractic services (Exempts IPA's) (HB 120).

While these are the major priority issues that will be addressed by the Association during 1981, there will undoubtedly be others which will require considerable activity in support of their passage or defeat.

Professional Liability — Continuing evaluation of additional legislative and legal remedies that may favorably impact on the crucial issue of professional liability remains a top priority of the Association. A report on the status and activities of the FPIR is included in Report A of the Board.

COMMITTEE ON NATIONAL LEGISLATION

The Board approved the following objectives for the Committee on National Legislation:

- Continuance of the spring visitation to Washington.
- Encourage county medical societies to invite their congressman to address the county medical society during the year.
- Regular visitations to Washington by the Chairman of the Council on Legislation, Chairman of the Committee on National Legislation and staff.

THIRD HOUSE OF DELEGATES

Council on Legislation

The Report of the Council on Legislation was adopted.

Council on Legislation

Louis C. Murray, M.D., Chairman

Most of the work of the Council on Legislation is accomplished through activities of its two committees: the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two major committees.

Committee on National Legislation — This committee consists of the key contact physicians for each member of the Florida delegation of the U.S. Senate and the U.S. House of Representatives. Members of this committee have kept in close touch with their assigned senators and congressmen on national legislative matters of interest to the FMA and American Medical Association.

The Association has maintained active liaison with members of the Florida Congressional Delegation on key legislative issues. Numerous conferences in Washington between FMA staff, key contact physicians and selected congressmen were necessary in order to carry out FMA and AMA policies on these issues. In addition to these individual visits, a comprehensive visitation was conducted by FMA key contact physicians and officers with the two U.S. Senators and House members who served on committees with jurisdiction over key health issues. This continuing personal liaison resulted in excellent cooperation from Florida's delegation.

The issues that necessitated major action by the FMA and contact physicians were:

- Support for the McClure-Melcher Amendment to the FTC Authorization Bill. This amendment, which failed by two votes in the Senate, would have prohibited preemption by the FTC of state's rights to regulate the professions and prohibited action by the FTC against non-profit medical, legal and dental associations.
- Successful opposition to several Medicare/Medicaid amendments that were part of the Budget Reconciliation process, including:
 - Preferential reimbursement to HMO's.
 - Expansion of chiropractic benefits in Medicare.
 - Limitations of "freedom of choice" in the access to and purchase of Medicaid services.
 - New criteria for determining reasonable cost of hospital services.
 - Limitation on reimbursement for hospital-associated physicians.
 - Competitive bidding for medical services under Medicaid.
- Opposition to expanded catastrophic health programs not consistent with FMA/AMA policy guidelines.
- Support for increased pay incentives for military and VA physicians.

The Ninety-Seventh Congress promises to be increasingly active in federal health legislation. Among the key issues that will be considered that are of particular interest to the FMA are:

1. Phase out funding for PSRO's.
2. Establishment of a truly local health planning process and elimination of the current federally mandated HSA-SHCC regulatory planning system.
3. Termination of preferential treatment and subsidy for HMO's.
4. Elimination of the present National Health Services Corps.

This will require the Association to continue to maintain close liaison with Florida's Congressional Delegation and with the AMA Washington Office.

Committee on State Legislation — The Committee has had

another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Four formal meetings of the committee have been held, along with informal conferences among committee members as items of an urgent nature arose.

Consistent with the policies developed by the FMA House of Delegates, the Committee has worked closely with the Board of Governors in developing our legislative program for the 1981 session of the Florida Legislature.

The following items summarize the Committee's activities.

1. The legislative program is continuing to function under the supervision of Donald S. Fraser Jr., Director of Legislative Affairs. He has been materially assisted by Mrs. Nancy Moreau, Legislative Analyst, George S. Palmer Jr., Associate Director of Legislative Affairs, and Jim McCloy, Director of FMA Government Programs Department. Particularly helpful to the legislative activity has been the FMA Branch Offices. These have greatly increased the Association's ability to maintain liaison with county medical societies, contact physicians and members of the Legislature.
2. The Capitol Dispensary. The Committee placed major emphasis on working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Delma Hart, R.N., has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the Doctor of the Day program.
3. The Committee on State Legislation is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. In addition, priority attention has been directed toward increasing the role of the Auxiliary in the Association's efforts. In order to effectively accomplish this, training workshops have been carried out in each county medical society and additional workshops have been held with Auxiliary organizations.
4. Publications. A legislative bulletin was published every week during the legislative session and periodically between sessions. The bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A listing of all bills monitored by the Capital Office is sent on a regular basis to county medical society executives and legislative chairmen. In addition, summaries and copies of key legislative proposals are distributed to key physicians and Auxiliary leaders, and each key contact physician has been given a specially designed notebook for either state or national legislation.
5. 1980 Legislative Accomplishments. During the 1980 legislative session, there were more than 350 legislative proposals that required action by the State Legislative Committee or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

- The FMA overcame major opposition from several organizations to pass legislation which allows for recovery of costs and attorney fees in medical malpractice suits.
- The law requiring posting of consumer complaint signs in physicians' offices was repealed.
- The FMA was also successful in passing legislation to:
 - Repeal law which required disclosure of physician's personal medical records to investigators from the Department of Professional Regulation.
 - Extend sovereign immunity to physicians employed by the State.

The following issues were successfully **opposed** by the FMA:

- Hospital staff privileges for chiropractors.
- State takeover of county health units.
- Prohibition for referral of patients to a hospital where the physi-

cian has an ownership interest.

- Mandated use of problem-oriented medical records in all hospitals in Florida.
 - Maintenance of elective surgery records by hospitals.
 - Repeal of 1980 Workers' Compensation fee increase for physicians.
 - Lowering of medical licensure standards.
 - Requirement for use of triplicate prescriptions.
 - Access to physicians' office records without due process when Auditor General is investigating Medicaid fraud.
6. Major Legislative Priorities for 1981 Session. The major legislative objectives, as of the date of this report, for the 1981 session of the Florida Legislature as developed by the FMA House of Delegates and the Board of Governors are:

- Resolve the problems in the ARNP law relating to scope of practice, educational criteria, and supervision required.
- Provide adequate funding for Florida's public health programs.
- Provide medical supervision and capability for long-range planning to Florida's EMS program.
- Provide increased funding for physician's services in Medicaid.
- Continue Medical Malpractice JUA.
- Provide adequate funding for perinatal programs.

Defeat of the following legislative proposals:

- Use of drugs by optometrists.
- Licensure of lay midwives.
- State takeover of county health units.
- Mandated use of problem-oriented medical records by hospitals.
- Lowering of medical licensure standards.

A supplemental report will be prepared by the Committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline up-to-date progress of the FMA legislative program made during the 1981 Legislative Session. It will also include other important state legislative items which might develop prior to the FMA Annual Meeting.

Supplemental Report

The Supplemental Report of the Council on Legislation was adopted.

Supplemental Report Council on Legislation

This is to update the Report of the Council on Legislation printed in the Delegates handbook. This report reflects the status of legislation as of April 24, 1981.

Legislative Status of Priority Objectives as Approved by the Board of Governors

1. **Support** — Legislation which would allow the State Board of Medical Examiners to enact appropriate guidelines for the development of protocols and the physician supervision required for Advanced Registered Nurse Practitioners operating in accordance with protocols. **HB 903** referred to Tourism and Economic Development Committee — No Action. **SB 889** — No Action, No Referral.
2. **Oppose subsidy for State employees enrolling in HMO's** — No Action.

3. **Oppose rewrite of the Physical Therapy Act** — includes a redefinition of physical therapy and elimination of requirements for physician prescription for services (**SB 328**). **SB 328** — Bill substantially revised and passed by Government Operations Committee, withdrawn from Health and Rehabilitative Services Committee, now in Appropriations Committee. Revisions to bill reinstated requirement for physician prescription and removed other objections.
4. **Oppose mandated use of problem-oriented medical records (SB 106)** — **SB 106** — referred to Health and Rehabilitative Services Committee — No Action.
5. **Oppose elimination of current criteria for issuance of temporary or limited medical licenses (SB 182, HB 711)** — **SB 182** — Substantially revised. Committee substitute favorably passed by Health and Rehabilitative Services Committee. **CS/SB 182** — provides for a public health certificate to be issued to practice medicine under certain conditions. **CS/SB 182** is now on the Senate Calendar. **HB 711** — referred to Tourism and Economic Development Committee — No Action.
6. **Oppose state-takeover of county health unit and development of primary care programs in county health units (SB 162)** — **SB 162** — referred to Health and Rehabilitative Services Committee, Governmental Operations Committee and the Appropriations Committee — No Action.
7. **Oppose authorization for optometrists to use and prescribe drugs (SB 349, HB 482)** — **SB 349** — Committee substitute favorably passed by Health and Rehabilitative Services Committee. Now referred to Commerce Committee. **HB 482** — Referred to Tourism and Economic Development Committee — No Action.
8. **Oppose licensure of homeopathic physicians (HB 49, SB 1017)** — **HB 49** — Referred to Tourism and Economic Development Committee, Appropriations Committee — No Action. **SB 1017** — No Action, No Referral.
9. **Oppose hospital staff privileges for chiropractors (HB 242, SB 979)** — **HB 242** — Amended in subcommittee of Health and Rehabilitative Services Committee to strike hospital privileges, however, retains outpatient referral for diagnostic tests. Now in full Health and Rehabilitative Services Committee. **SB 979** — No Action, No Referral.
10. **Oppose establishment of a school of chiropractic in Florida (HB 768)** — Withdrawn from consideration by sponsor.
11. **Oppose "Freedom of Choice" proposal for injured workers covered by Florida's Workers' Compensation Program (SB 470)** — Referred to Commerce Committee — No Action.

Status of Other Issues of Concern to Florida Physicians

1. **Adequate funding for perinatal program** — Increased funding for the perinatal program is contained in both the House and Senate budgets — exact amount unknown.
2. **Funding for medical supervision and long-range planning of Florida's Emergency Medical Services Program** — No funding provided at this time.
3. **Continuation of Medical Malpractice JUA (HB 279, CS/SB 607)** — **HB 279** — Favorably passed by House. Now referred to Senate Commerce Committee. **SB 607** — Favorably passed by Senate Commerce Committee. Now on Senate Calendar.
4. **Licensure of Clinical Psychologists, School Psychologists, Marriage and Family Therapists, mental health counselors and clinical social workers (CS/HB 28)** — **CS/HB 28** — Favorably passed by Tourism and Economic Development Committee. Now in Appropriations.

5. **Licensure of Homeopathic Physicians (HB 49)** — HB 49 — Referred to Tourism and Economic Development Committee and Appropriations Committee — No Action as of this date.
6. **Authority for podiatrists to use nurse anesthetists (HB 713, SB 985)** — HB 713 — Referred to Tourism and Economic Development Committee — No Action. SB 985 — No Action or referral.
7. **Use of I.A.T. (immuno-augmentative therapy) for cancer treatment (HB 747, SB 347)** — HB 747 — Referred to Health and Rehabilitative Services and Appropriations Committee — No Action. SB 347 — Favorably passed Senate Health and Rehabilitative Services Committee — Now on Senate Calendar.
8. **Mandate for Medicaid to reimburse for podiatry services (HB 773)** — HB 773 — Referred to Health and Rehabilitative Services Committee and Appropriations Committee — No Action.
9. **Licensure of Naturopathy (HB 979, HB 830, SB 949)** — HB 830 — Referred to Tourism and Economic Development Committee — No Action. HB 979 — Referred to Tourism and Economic Development Committee — No Action. SB 949 — No Action or referral.
10. **Hospital staff privileges (HB 909)** — This bill would prohibit hospital from requiring AMA residencies as a condition for admitting specialists to the hospital staff. It also requires a written response defining the specific reasons for denial of privileges. HB 909 — Referred to Health and Rehabilitative Services Committee — No Action.
11. **State funding for HSA's (HB 940, SB 707)** — Appropriates \$3 million in state funds for HSA programs in Florida. An additional \$500,000 will be generated in fees from certificate of need applicants. HB 940 — Referred to Health Care Cost Containment and Planning Committee and Appropriations Committee — No Action. SB 707 — No Action or referral.
12. **Declaration in license application as to acceptance of Medicare assignment (SB 391, HB 973)** — Requires physicians to state on license application (new or renewal) as to whether they will accept Medicare assignment. HB 973 — Referred to Tourism and Economic Development Committee and Appropriations Committee — No Action. SB 391 — Referred to Health and Rehabilitative Services Committee — No Action.

13. **Primary care clinics for aged through county health units (SB 460)** — Establishes gerontology clinics in county health departments for provision of health services to aged. SB 460 — Referred to Health and Rehabilitative Services Committee — No Action.
14. **"Freedom of Choice" of physicians for injured workers (SB 470)** — This bill allows employee to make the initial selection of physician, rather than the company. SB 470 — Referred to Commerce Committee — No Action.
15. **Registered Pharmacist to be called "Doctor of Pharmacy" (HB 803, SB 679)** — Pharmacists in Florida would be called "Doctor of Pharmacy" under the provisions of this legislation. HB 803 — Referred to Tourism and Economic Development Committee — No Action. SB 679 — Referred to Health and Rehabilitative Services Committee — No Action.

Other Late Developing Legislative Activities

The Council asks for permission to introduce to the Reference Committee any item of major significance that might have arisen in the Legislature between April 24th and the time of the FMA meeting.

RESOLUTION 81-15

Limiting the Percentage Charged by Attorneys for Contingency Fees Dade County Medical Association

The Reference Committee moved an amendment to Resolution 81-15, by changing the last "Resolved" to read:

"RESOLVED, That in order to greatly reduce the cost of medical care that the FMA assist the news media in exposing the fact that contingency fees unrestricted are unconscionable and are contributing to the continuing rapid increases in premiums levied by insurance companies, which in turn are passed on to patients."

A substitute amendment was presented, which would read:

"RESOLVED, That in order to help decrease the escalating cost of medical care that the FMA assist the news media in exposing the fact that present contingency fees are unconscionable particularly in light of ever-increasing excessive awards."

The motion to adopt the substitute amendment carried, and Resolution 81-15 was adopted as amended.

RESOLUTION 81-15

Limiting the Percentage Charged by Attorneys for Contingency Fees

RESOLVED, That the FMA establish as one of its top priority legislative goals the promotion of legislation to limit contingency fees in all civil proceedings (across the board), in order to help preserve not only the financial stability of the Patients Compensation Fund but to preserve the financial stability of premiums with all companies providing liability insurance in the State of Florida; and be it further

RESOLVED, That in order to help decrease the escalating cost of medical care that the FMA assist the news media in exposing the fact that present contingency fees are unconscionable particularly in light of ever increasing excessive awards



Past President Louis C. Murray, M.D., Orlando (left) and Hector Mendez, M.D., also of Orlando, escort Mrs. T. Byron Thames, wife of FMA's President, to the head table

RESOLUTION 81-17

Federal Income Tax Deductions for Free Medical Care Rendered to Indigents

Dade County Medical Association

The Reference Committee heard testimony in support of this Resolution; however, while it agreed with the concept and principle, it did not feel it feasible at this time, given the current political climate and budget reductions.

Upon recommendation of the Reference Committee, Resolution 81-17 was not adopted.

The Chairman expressed deep appreciation on behalf of the Committee to Miss Kaye Clark who performed so admirably as recorder for the Committee. The Committee also expressed thanks to all members of the Florida Medical Association who appeared before it and wished to express special thanks to Dr. Louis C. Murray and Dr. Frank Coleman, Chairman and Vice Chairman of the Council on Legislation and also to Dr. Joseph Von Thron, who served as the AMA Delegate advisor to the Committee. Dr. Eberly also expressed his thanks to the members of his committee for their hard work and outstanding service.

The motion of the Reference Committee that the Report of Reference Committee No. IV be adopted as a whole, as amended carried.

Dr. Perry recognized Dr. Ronald L. Seeley, President of the Hillsborough County Medical Society, for the purpose of introducing a Special Resolution recognizing the services of Mrs. Amelia Hapke. Mrs. Hapke had also been recognized by the Greater Tampa Chamber of Commerce for her many years of service to the medical



Mrs. Amelia Hapke, former Executive Vice President of the Hillsborough County Medical Association, retired last December after a quarter century of service with HCMA. Here she is introduced to the House of Delegates by Ronald L. Seeley, M.D., Tampa, President of HCMA.

profession. Mrs. Hapke was escorted to the podium by Doctors Coleman, McKell and Williamson.

Dr. Perry, recognized Dr. Eugene Peek who urged all delegates to contact as many AMA delegates as possible to support Dr. Rufus K. Broadaway for the AMA elective office of Vice Speaker. Dr. Peek said that there was every confidence that Dr. Broadaway would be elected.

Dr. Perry called the Chairman and members of Reference Committee V — Medical Economics, to present their report.

Report of Reference Committee No. V

Medical Economics

Dr. Brian P. Gibbons, Chairman, and his committee came forward to present the report of Reference Committee No. V — Medical Economics.

Report E of the Board of Governors

RECOMMENDATION E-1 JUDICIAL COUNCIL OPINION NO. 81-2 RESOLUTION 81-3

Physician Billing for Laboratory Services
Collier County Medical Society

The Reference Committee considered these three items together since they pertained to the same subject matter. The Committee heard much testimony regarding the subject of Physician Billing for Laboratory Services and appreciated the information given to it by various members who appeared before the Committee.

During the Committee's deliberations, extensive discussion took place regarding Recommendation No. E-1 of Report E of the Board of Governors.

The motion of the Reference Committee to amend Recommendation E-1 by deleting item No. 3 from the recommendation failed to carry.

A substitute motion from the floor to refer Recommendation E-1 back to the Board of Governors carried.

The Reference Committee recommended that the Judicial Council's Opinion No. 81-2 be adopted; however, a motion was made to refer Opinion No. 81-2 back to the Board of Governors. The substitute motion carried and Judicial Council Opinion No. 81-2 was referred to the Board. (Judicial Council Report, see page 566).

The Reference Committee recommended that Resolution 81-3 not be adopted; however, a motion was made to refer Resolution 81-3 to the Board of Governors. The motion carried and Resolution 81-3 was referred to the Board.



Reference Committee V (Medical Economics) listens intently to testimony offered by Benjamin A. Johnson, M.D., Tallahassee (standing), of the Florida Division of Worker's Compensation. Left to right: Franklin H. Pfeifferberger, M.D., Sarasota; Faris S.

Monsour, M.D., Jacksonville; Ms. Marcia Protheroe, Jacksonville, Recorder; Dr. Johnson; Brian P. Gibbons, M.D., Cocoa Beach, Chairman; Manuel L. Carbonell, M.D., Miami; and William P. Booras, M.D., Jacksonville (Alternate Member).

RESOLUTION 81-3**Physician Billing for Laboratory Services****[Not Adopted — Referred to the Board of Governors]**

Whereas, Implementation of Florida Statute 483.245 (1) Rule 10D-41.32 (5) would essentially eliminate a physician from providing medical laboratory reference services for his patients by restricting compensation without consideration for collectables, overhead or interpretation.

Whereas, Florida Statute 483.245 (1) restrains free trade and discriminates against physicians by not granting them the same rights to charge prevailing fees.

Whereas, The physicians of Florida have been singled out by the Department of Health and Human Services as a target for cost containment at the physician's expense by restricting reimbursement for laboratory services to the cost billed the physician by the reference laboratory for the test.

Whereas, The effect of the current stand of the AMA is to imply a lack of ethics by physicians attempting to supply and interpret laboratory reports for patients at a reasonable compensation; therefore be it

RESOLVED, That the FMA allow the practicing physician to charge the prevailing fee as the medical reference facility would when billing the patient directly and, be it further

RESOLVED, That the FMA through its representation in the AMA urge designation of this practice as medically ethical and, be it further

RESOLVED, That the FMA petition the legislature to repeal or modify discriminating Florida Statute 483.245 (1) and, be it further

RESOLVED, That should legislative repeal fail, judicial action should be pursued and, be it further

RESOLVED, That the Florida Medical Association initiate judicial action against the implementation of the Department of Human Health Services Rule under Medicare Part B restricting reimbursement for laboratory services to physician's cost, charged by the reference or independent laboratory and, be it further

RESOLVED, That the FMA establish an escrow account by a mandatory assessment of the membership, the amount to be determined by the executive board after conferring with council for the purpose of funding legal expenses in this matter.

Report E of the Board of Governors was adopted as amended.

Report E**of the****Board of Governors**

T. Byron Thames, M.D., Chairman

Specialty Screens — The Board reaffirmed the current FMA position of opposition to the application of Specialty Screens (Dual Fee Schedules) in Florida and also reaffirmed the Board's previous action that FMA, if invited, participate in the defense of the lawsuit filed by the Dade County Society of Internal Medicine against Blue Cross and Blue Shield of Florida, GHI and the Department of HHS, and that FMA's participation would be for the purpose of defending the position which has been adopted and reaffirmed by the FMA House of Delegates in opposition to specialty screens.

Physician Charges for Laboratory Services — The Board received as information the opinion rendered by the Judicial Council that physicians using medical laboratories should charge the patient exactly what the laboratory charges a physician, provided the physician may charge, in addition to the above, a reasonable charge for the acquisition of the sample and a reasonable handling charge.

The Board voted to reaffirm and submit to the House of Delegates the action taken by the Board regarding laboratory services in January 1970.

RECOMMENDATION NO. E-1**[Not Adopted — Referred to the Board of Governors]****THAT THE FOLLOWING POSITION REGARDING PHYSICIANS CHARGES FOR LABORATORY SERVICES BE ADOPTED:**

1. THAT IT IS PREFERABLE THAT THE LABORATORY, NOT THE ATTENDING PHYSICIAN, BILL AND COLLECT FROM THE PATIENT OR THIRD PARTY PAYOR FOR LABORATORY SERVICES. WHERE CIRCUMSTANCES MAKE THIS IMPRACTICAL OR WHERE INCREASED COSTS TO THE PATIENT WOULD RESULT, THE BILL SUBMITTED BY THE ATTENDING PHYSICIAN TO HIS PATIENT OR THIRD PARTY PAYOR SHOULD STATE THE NAME OF THE LABORATORY PERFORMING THE SERVICES FOR HIS PATIENT AND THE EXACT AMOUNT OF THE CHARGE PAID OR TO BE PAID BY THE PHYSICIAN TO THE LABORATORY. MEDICAL SOCIETIES ARE URGED TO USE ALL MEANS LEGALLY AVAILABLE TO THEM IN EFFECTUATING THE FOREGOING.
2. THE ATTENDING PHYSICIAN IS ENTITLED TO FAIR COMPENSATION FOR THE PROFESSIONAL SERVICE HE RENDERS. HE IS NOT ENGAGED IN A COMMERCIAL ENTERPRISE, HOWEVER, AND ANY MARKUP, COMMISSION, OR PROFIT ON THE SERVICES RENDERED BY A LABORATORY IS EXPLOITATION OF THE PATIENT.
3. IN BILLING PATIENTS FOR LABORATORY SERVICES WHICH ATTENDING PHYSICIANS PERFORM FOR THEIR OWN PATIENTS, THE BILL SHOULD PROVIDE INFORMATION TO SHOW WHERE SUCH SERVICES WERE PERFORMED, AS WELL AS AN ADEQUATE DESCRIPTION OF THE SERVICES PROVIDED AND THE SPECIFIC CHARGES MADE.

FMA Councils and Committees**COUNCIL ON HEALTH CARE FINANCING**

Workers' Compensation Claim Form — The Board approved a recommendation to the Florida Division of Workers' Compensation that the AMA approved uniform claim form be adopted as the medical claim for for physicians' services used by the program.

The Board also authorized FMA to share in the cost of distributing to FMA members a manual for filing the AMA uniform health insurance claim form, which is the form to be used in meeting the requirements of Florida law. The manual incorporates the billing requirements for Medicare, Medicaid, CHAMPUS, DHRS programs, commercial insurance and Workers' Compensation.

Workers' Compensation Legislation — The Board expressed support for legislation which would remove the requirement for a sworn statement under penalty or perjury to the appended or stamped on every Workers' Compensation claim form.

Workers' Compensation Update — The Board requested that an update on Workers' Compensation for the information of the membership be prepared for inclusion in *The FMA Journal*.



FMA Secretary Robert E. Windom, M.D. (left) and President T. Byron Thames, M.D., savor a light interlude to the serious proceedings of the House of Delegates.

James F. Richards Jr., M.D. — The Board commended Dr. James F. Richards Jr., for his many years of work and effort expended on behalf of the members of the Florida Medical Association in seeking improvements in Florida's Workers' Compensation program, including equitable allowance for physicians' services.

Concurrent Claims Review for Workers' Compensation — As reported in the Council on Health Care Financing's annual report, the Florida Medical Foundation has entered into a contract with the Division of Workers' Compensation to provide peer review for Florida's Workers' Compensation program.

The Board has also approved a cooperative effort between the Florida Medical Foundation and PIMCO to develop a program of concurrent claims processing for the Workers' Compensation program.

The Board concurred with the feeling of the Council that the assumption of the role of government as a third party insurer does nothing but aggravate problems and diminish the benefits of our current health care financing and delivery system. The development of a concurrent claims processing program will:

1. Provide a means for cooperative efforts between industry and physicians to resolve problems in health care.
2. Improve efficiency in processing medical care claims.
3. Develop effective peer review of medical care in the private sector.
4. Create a method to evaluate the adequacy of health care programs and consider the appropriateness and cost of medical care provided in that area by those involved.
5. Facilitate the evolution of alternative health care financing and delivery systems in accord with demonstrated need.

Such a program can be implemented voluntarily in the private sector only if the Florida Medical Foundation takes the initiative in offering peer utilization review for employee health programs and workers' compensation insurance to industry and business in conjunction with insurance or administrative service organizations.

Employers' Health Action Coalitions — In September 1979, at the invitation of Governor Bob Graham, a number of chief executive officers of some of South Florida's major employers met to discuss what role they could play collectively in stabilizing the costs of health care for their employees. July 1980 saw the creation of the Employer's Health Action Coalition of South Florida, Inc.

A representative from the Governor's office reported to the Council on Health Care Financing the Governor's interest in exploring ways in which the State, as the largest employer in Florida, can work with other employers to help hold down the costs and provide direction to the health care system in response to the investment being made by them.

This coalition concept, started in South Florida, will be taken to other areas of the state such as the Tampa Bay Area, Jacksonville, Pensacola and Orlando. These coalitions will be started to:

1. Contain health care costs for employers and employees without sacrificing essential health needs.
2. Stimulate price and service competition among health care providers and insurers.
3. Improve the cost-effective delivery of medical services and control wasteful or abusive practices.
4. Enhance healthful lifestyles and enhance wellness among employees.

The Board of Governors has expressed to the Governor, organized medicine's concern that thus far, providers have been excluded from any representation in a policy making role in the coalitions and have only been utilized in a peripheral advisory capacity.

Relative Value Studies — The Board authorized the Committee on Relative Value Studies to proceed with the update of the 1975 RVS using current procedural terminology, fourth edition coding and nomenclature with the ground rules, modifiers and guidelines from the 1975 *Florida Relative Value Studies*, with modifications as necessary, and further to use the data base of physicians' charges from Blue Cross/Blue Shield and other sources as the basis for calculating the unit values with individual analysis conducted by a statistician to be selected by the Committee.

The Board reaffirmed current policy that the relative value studies is intended solely for the purpose of aiding in determining relativity for physicians services only, and requested that the committee on RVS, in carrying out its functions, submit all questions and recommendations which may arise regarding modifiers to the FMA Executive Committee for determination of policy. The Board commended Dr. Mattison and members of the RVS Committee for their efforts in undertaking this difficult task.

Medicaid — Promotion of HMO's — The Board voted to express to the Secretary of the U.S. Department of Health and Human Services, the Governor of Florida, and the Secretary of the Department of HRS opposition to any Medicaid funds needed for patient care being used by HMO's/PHP's for the purpose of marketing their programs to Medicaid eligibles.

Government Subsidies for Medical Delivery Programs — The Board expressed opposition to any form of government subsidy for medical delivery programs such as HMO's and PHP's to the exclusion of other medical care delivery programs or systems.

Health Maintenance Organizations — The Board approved the recommendation to utilize the AMA study on HMO's as amended by the AMA House of Delegates in reviewing and monitoring HMO's in Florida and that FMA component county medical societies be requested to monitor HMO activity in their area and report any information or concerns to the FMA Council on Health Care Financing.

Medicaid Funding for Physician Services — The Board directed that high priority be placed on the passage of legislation to increase funding for physician ambulatory care services provided under the Medicaid program.

CHAMPUS — The Board assigned responsibility for CHAMPUS to be included in the activities of the Committee on Medicare/Medicaid.

There is an increasing concern expressed by physicians living in communities with a large military population that policies, determined in California for Florida CHAMPUS patients, need to be followed and at times challenged.

Advanced Negotiations Training Seminar — The Board approved that the Council on Health Care Financing and the Florida Physicians Association jointly co-sponsor with the AMA Department of Negotiations an Advanced Negotiations Training Seminar in February 1981 in Tampa. It was necessary for the seminar to be cancelled due to inadequate registration.

Council on Health Care Financing

The Report of the Council on Health Care Financing was adopted.

Council on Health Care Financing

William W. Thompson, M.D., Chairman

This Association year saw the creation of the Council on Health Care Financing. In discharging its duties under the Florida Medical Association Bylaws, members of the Council met twice during the year.

A summary of the activities of the committees which make up the Council are reported below:

Committee on Relative Value Studies: The Committee on Relative Value Studies, chaired by Joel W. Mattison, M.D., is in the process of revising the *1975 Florida Relative Value Studies*.

The adoption, to be implemented later in 1981, of the *Current Procedural Terminology — Fourth Edition (CPT-4)* by the Health Care Financing Administration as the universal coding and nomenclature for Medicare and Medicaid will make the *1975 Florida Relative Value Studies* obsolete.

The Committee on Relative Value Studies voted unanimously at its September 6, 1980, meeting to recommend to the Council and Board of Governors that the *1975 RVS* be updated based on the broadly accepted *CPT-4* with ground rules, modifiers and guidelines coming from *CPT-4* and the *1975 RVS*.

The Committee on RVS reviewed alternative methods to use in calculating the unit values for the procedures in the new RVS. The survey technique used previously was felt to be time consuming and expensive. After contacting Florida Blue Shield and GHI to determine if they could provide information based on physician charge data, the committee learned that a data base based on forty million individual charges made by Medical Doctors could be utilized. A review of the methodology and data base by an outside independent statistician convinced the Committee that the data base will allow for the development of the most accurate RVS to date.

Presidents of specialty groups and representatives on the Council on Specialty Medicine have been contacted and requested to assist the Committee on RVS in the task of reviewing one-by-one the instructions, modifiers and guidelines from the *1975 RVS* for inclusion in the *1981 RVS*. The tentative date for completion of the *1981 Florida Relative Value Studies* is late summer or early fall.

Committee on Workers' Compensation: The Committee on Workers' Compensation, under the leadership of the Chairman, James F. Richards Jr., M.D., has monitored the activities of the Legislature and Division of Workers' Compensation.

The Division of Workers' Compensation at a public hearing, held on petition by the Florida Medical Association, replaced the previously used LES Forms WCC-2 and WCC-9 with the State of Florida's Uniform Health Insurance Claim Form. This claim form is identical to the AMA Uniform Health Insurance Claim Form.

On February 16, 1981, Dr. Richards presented testimony before the Panel on Workers' Compensation Medical Services Fee Schedule in which he expressed appreciation that the *Florida Workers' Compensation 1981 Medical Services Fee Schedule* includes many procedures not formerly listed and that the four-digit procedure codes had

been changed to the commonly accepted five digit codes. Concern was expressed over the very low amounts allotted for consultative services and physician fees in general. Specific attention was given to the fact that the fee increase that went into effect July 1, 1980, was based on data that is now two years old. Since August 1979, through November 1980, the "General Inflation Rate" has risen 16%. Ignoring the need for updating the Fee Schedule until it becomes a crisis has led in the past to many hard feelings, misunderstandings, costly public hearings and legal actions. The Legislative mandate to review the Fee Schedule on a yearly basis offers an opportunity to bring order to an otherwise chaotic situation.

The Committee on Workers' Compensation reviewed the state law requiring a sworn perjury statement be stamped or appended to each and every claim form and recommended that inasmuch as the insurance statutes make it a felony for making false statements on medical claims that are filed, it is absolutely unnecessary for the sworn statement to be stamped on or appended to each and every form. It is hoped the Legislature will lift this requirement.

Committee on Medicare/Medicaid/CHAMPUS: The Committee on Medicare/Medicaid/CHAMPUS, chaired by Frank B. Hodnette, M.D., spent a large portion of its time responding to complaints made by members of the Association. Investigations were made by the staff and appropriate action taken.

The Committee worked with the Florida Medicaid Program through Donald G. Nikolaus, M.D., and staff, making sure that the Medicaid Redevelopment Study included the concerns and problems faced by physicians in dealing with the program. Also, as a result of this effort, the Department of Health and Rehabilitative Services recommended to the Governor for inclusion in his budget that there be a seventeen million dollar increase in physician fees over the next biennium.

A questionnaire was sent to each county medical society regarding problems with the CHAMPUS program, and as a result, staff will be meeting with CHAMPUS representatives to determine: Why it takes so long to process claims; receive answers to correspondence; the methodology used in determining fees; and reason for the extensive paper work requirement.

The Committee corresponded with Alicia Jacobs, J.D., Deputy Assistant Secretary for Medicaid regarding proposed Administrative Rule 10C-7.524, "Medicaid Contracts with Health Maintenance Organizations and Prepaid Health Plans". Special attention was given to the proposed use of Medicaid funds for the purpose of marketing the contractors' prepaid health care plan. According to Deputy Secretary Jacobs, nothing in federal regulation or state law precludes HMO's and PHP's from using a part of the capitation rate to market their program to Medicaid eligibles.

Committee on Health Systems Agencies: The Committee on Health Systems Agencies, chaired by Paul J. Popovich, M.D., monitored the statewide implementation of PL 93-641 and PL 96-79. Particular attention was given to the activities of the Statewide Health Coordinating Council (SHCC), the State Health Planning and Development Agency (SHPDA), and the Florida Association of Health Systems Agencies, Inc. Staff attended all meetings of the SHCC, SHCC subcommittees, and task forces. Special attention was given to the development of standards and criteria for "Appropriateness Review".

The Committee and Gary Clarke, J.D., Deputy Assistant Secretary for Health Planning, worked out an agreement in which the Florida Medical Association will be contacted by his office and asked to establish specialty panels that will provide the SHPDA staff with direction and medical input at the developmental stage of a fascicle for the State Health Plan. In the past, the FMA has created specialty panels which had to rewrite various fascicles of the State Health Plan in their attempt to get them approved by the SHCC instead of the original product developed by the SHPDA staff.

The Committee on Medical Delivery Systems: The Commit-

tee on Medical Delivery Systems, under the chairmanship of H. Phillip Hampton, M.D., reviewed the many problems faced by physicians providing services for injured workers under the Florida Workers' Compensation Program because of claims being processed by a California based company with little input from Florida physicians. The Committee is exploring the possibilities of having a claims processing company established in Florida that will be receptive to the concerns of physicians. Also, any peer review for such a program should be done by the Florida Medical Foundation.

A meeting with Mr. Peter O'Donnell, Senior Staff Analyst, Governor's Office, determined that in September 1979, at the invitation of Governor Bob Graham, a number of chief executive officers from some of South Florida's major employers met to discuss what role they would play collectively in stabilizing the cost of health care for their employees. The result of the Governor's initiative was the creation in July 1980, of the "Employers Health Action Coalition of South Florida, Inc." The coalition concept started in South Florida will be taken to other areas of the state. The goals of the coalitions will be: 1) Contain health care costs for employers and employees without sacrificing essential health needs; 2) Stimulate price and service competition among health care providers and business; 3) Improve the cost effective delivery of medical services and control wasteful or abusive practices; and 4) Enhance helpful lifestyles and good health among employees.

The Committee is continuing its efforts to develop an Employer Health Program Management and Evaluation System which will assure that physicians will have a definite part in working with and having input into further actions of major employers and future coalitions.

Supplemental Report Council on Health Care Financing

This is to update the Report of the Council on Health Care Financing printed in the Delegate's Handbook. This report reflects the status of the Division of Workers' Compensation conversion to the new AMA Modified Claim Form (OP-405) (BCL-9).

The Florida Medical Association in December of 1980 announced to the entire membership via the *Briefs* that the Florida State Department of Insurance had agreed to adopt the AMA Modified Claim Form (OP-409) as the standard form for physicians to be accepted by all insurers and all programs administered by the Department of Health and Rehabilitative Services.

The FMA also advised in a subsequent *Briefs* that at the request of the FMA, the Division of Workers' Compensation had also agreed to adopt the form. The Department of Insurance agreed that the conversion date to the form would be July 1, 1981. This was to allow physicians and third-parties sufficient time to adapt to the revised form.

Unfortunately, Workers' Compensation Division Bulletin No. 42, dated March 27, 1981, sent to insurance carriers and self-insurers, indicated that the Division would no longer accept the "old" medical forms BCL-2 and BCL-9 after May 1, 1981.

The Council is pleased, however, to report that through the understanding and cooperation of the Division of Workers' Compensation all carriers and self-insured employers have been requested by Workers' Compensation Bulletin No. 45 dated April 24, 1981, to continue accepting any reasonable billing form for services provided on or prior to June 30, 1981. Any service provided after that date must be billed on the new BCL-9 (AMA OP-409) form. The July 1 conversion date also applies to all programs of the Department of Health and Rehabilitative Services and all insurance carriers. The required information on diagnosis, medical procedures, services, date of service, supplies and fees still may be met by an attachment to the physician claim form. However, for the purpose of filing Medicaid claims, such attachments will still be prohibited.

It has also been brought to the Council's attention that some physician billing services have not been informed or kept up with the changes in the implementation of ss 627.611 (Uniform Health Insurance Claim Forms) as developed by the Department of Insurance, and have been unaware of the change to the AMA OP-409 by the Division of Workers' Compensation. FMA members should be sure that their supplier is aware of the change to the AMA OP-409 on July 1, 1981.

The FMA and others cooperated with the Department of Insurance in developing a technical manual to assist FMA members and their office staff in completing the new form for all programs including Workers' Compensation. When completed, the FMA will send a copy of the manual to all FMA members. The FMA will keep the membership advised of any further action relative to the implementation of the uniform claim form (ss 627.611).

Florida Health Data Corporation

The Report of the Florida Health Data Corporation, Inc., was adopted.

Florida Health Data Corporation, Inc.

James L. Borland Jr., M.D., Immediate Past President

The Florida Health Data Corporation continues to have as its primary goal to establish and generate an independent health data bank which is accurate, timely, comprehensive and controlled by the private sector.

The initial project of the corporation is the establishment of the Hospital Management and Medical Information System (HMMIS) which is a hospital discharge data abstracting service for the State of Florida. Recently, this effort has experienced a setback as the program decreased from thirty (30) hospitals to twenty-two (22) with little hope of adding more hospitals under present conditions. The Florida Health Data Corporation has been fully operational for over a year but resistance to change has been expressed by both hospital administrators and medical record directors.

The Board of Directors at their February 17, 1981, meeting decided to cut its marketing expenses while at the same time guaranteeing good service to the subscribing hospitals at a minimum for the remainder of 1981. Consideration is being given to the possibility of merging or selling the abstracting service to an existing company. Also, the Board is investigating the possibility of FHDC becoming a data broker through buying and selling of data rather than abstracting it.

The members of the Board continue to feel that there is a need for the Florida Health Data Corporation's existence, especially with the interest in health and medical data expressed by the state and federal governmental agencies as well as major employers and insurance carriers.

Report of Florida Medical Foundation — PMUR

The section of the Florida Medical Foundation's report concerning PMUR was adopted. (See Florida Medical Foundation Report, page 563).

RESOLUTION 81-10

Discriminatory Reimbursement by Medicare Seminole County Medical Society

The Reference Committee moved to amend Resolu-

tion 81-10 by changing the "Resolved" to read:

"RESOLVED, That the Florida Medical Association petition the Medicare intermediary and Blue Cross/Blue Shield to pursue the two-charge area concept rather than the present four-charge area concept."

An amendment to the Reference Committee's motion was made to substitute the word "carrier" for "intermediary". The amendment failed to carry, and the Reference Committee's motion to amend failed to carry.

A motion from the floor to refer Resolution 81-10 to the Board of Governors carried.

RESOLUTION 81-10

Discriminatory Reimbursement by Medicare

[Not Adopted — Referred to the Board of Governors]

Whereas, Rural area physicians are victims of discriminatory reimbursement by Medicare;

Whereas, Medicare, Blue Cross/Blue Shield should pay exactly the same amount for the same procedure whether performed at an urban or rural area;

Whereas, Medical maldistribution is the result of this discriminatory reimbursement; therefore be it

RESOLVED, That the FMA petition our legislators in Tallahassee to bring about the end of this gross inequity between the fees paid urban and rural physicians in the State of Florida.

RESOLUTION 81-12

Voluntary Effort

Hillsborough County Medical Association

The motion of the Reference Committee that Resolution 81-12 be amended by changing the words "full time" to "adequate" carried.

Resolution 81-12 was adopted as amended.

RESOLUTION 81-12

Voluntary Effort

RESOLVED, That the Florida Medical Association provide adequate staff support to the Florida Committee on the Cost of Medical Care (VE Committee) to develop a strong and viable cost containment effort in Florida; and be it further

RESOLVED, That the Florida Medical Association develop a plan to seek cost sharing of staff support from other component organizations of the Florida Voluntary Effort.

RESOLUTION 81-16

Workers' Compensation Fee Schedule

Dade County Medical Association

The Committee discussed this resolution and made note of that portion of the State Law 440.13(3)(a) quoted as follows:

"All fees and other charges for such treat-

ment or service, including treatment or service provided by any hospital or other health care provider, shall be limited to such charges as prevail in the same community for similar treatment of injured persons of like standard of living and shall be subject to rules adopted by the division, which shall **annually incorporate schedules of maximum charges, for such treatment or service as determined by a three member panel consisting of the Secretary of Labor and Employment Security, the Insurance Commissioner, and the state medical consultant of the Division of Workers' Compensation . . .**"

In view of the new Workers' Compensation Law, the Committee felt that the effect of this law should be given adequate time to prove itself. The Committee further recognized the inadequacies of the Workers' Compensation Fee Schedule and endorsed the FMA's continued negotiations with the Division of Workers' Compensation for an acceptable fee schedule.

Upon recommendation of the Reference Committee, Resolution 81-16 was not adopted.

The Reference Committee expressed its gratitude to those who appeared before the Committee.

Dr. Gibbons expressed his appreciation to his Committee which he said was a most efficient and informed one and expressed the Committee's appreciation to Mr. Philip Gilbert, FMA staff and the efficient secretarial help of Ms. Marcia Protheroe.

The motion of the Reference Committee that the Report of Reference Committee V be adopted as a whole as amended carried.

Speaker of the House, Dr. Perry, invited new FMA President Dr. Sanford A. Mullen to assume the chair.

Dr. Mullen took the chair to introduce to the House two new Chairmen of FMA Councils for 1981-82. First, Dr. Mullen introduced Dr. Arthur Eberly as Chairman of the Council on Specialty Medicine, and second Dr. Charles B. Hayes as Chairman of the Council on Health Care Financing. Dr. Mullen said that no further changes had been made to existing Councils which remained as follows:

Council on Scientific Activities — Dr. Yank D. Coble
Council on Legislation — Dr. Louis C. Murray
Council on Medical Services — Dr. Joseph T. Ostroski
Judicial Council — Dr. James A. Winslow

Elections

President - Elect

The Speaker opened the floor for nominations for the office of President-Elect.



Sarasota County Delegate Karl R. Rolls, M.D. (checked coat) escorts Robert E. Windom, M.D., Sarasota, to head table when Dr. Windom was unanimously named President-Elect of FMA. In right photograph, the new President-Elect shares a light moment with longtime friend and fellow internist Charles K. Donegan, M.D., St. Petersburg, who presented him with an office sign imprinted "First Class Doctor".

Dr. Karl Rolls, Chairman, Sarasota Delegation to the FMA, and Dr. William E. DesPortes, President, Sarasota County Medical Society, placed in nomination the name of Dr. Robert E. Windom of Sarasota.

Dr. Rolls and Dr. DesPortes' nomination was seconded by Dr. Charles K. Donegan of St. Petersburg; Dr. Luis Carrillo of Polk County; Dr. Clarence M. Gilbert of Orange County; Dr. James T. Cook of Panhandle Medical Society; Dr. Warren Lindau of Dade County; Dr. Calvin W. Martin of DeSoto-Hardee-Glades; Dr. Reginald Stambaugh of Palm Beach; Dr. Charles B. Hayes of Duval; Dr. Francis C. Coleman of Hillsborough.

Nominations were closed, and Dr. Robert E. Windom of Sarasota was elected President-Elect.

A motion that the House of Delegates give its unanimous support to Dr. Windom carried.

**Vice President
Secretary
Treasurer**

Speaker of the House/Vice Speaker

The floor was opened for nominations for the office of Vice President. Dr. Perry suggested that all of the names of the announced unopposed candidates for Vice President, Speaker of the House, Secretary, Treasurer, and AMA Delegates and Alternates be placed in nomination and that the nominations be closed. It was so moved and the motion carried. All nominees to the state offices were elected by unanimous vote of the House and are:

Vice President — Gerold L. Schiebler, M.D.

Speaker of the House — James B. Perry, M.D.

Secretary — Luis M. Perez, M.D.

Treasurer — J. Russell Forlaw, M.D.

Vice Speaker of the House — Franklin B. McKechnie, M.D.

AMA Delegates and Alternates

Terms 1/1/82 — 12/31/83

Seat #4 — Delegate — Burns A. Dobbins, M.D.

Alternate — Eugene G. Peek Jr., M.D.

Seat #1 — Alternate — Vincent P. Corso, M.D.

Seat #6 — Delegate — Rufus K. Broadaway, M.D.

Seat #7 — Delegate — Joseph C. Von Thron, M.D.

AMA Delegate — Seat No. 1

The Speaker opened the floor for nominations for the AMA Delegate for Seat No. 1.

Dr. T. Byron Thames' name was placed in nomination, nominations were closed, and the motion to elect Dr. Thames as AMA Delegate — Seat No. 1 carried unanimously.

AMA Alternate — Seat No. 6

The Speaker opened the floor for nominations for the AMA Alternate Seat No. 6.

Dr. Charles B. Kahn was nominated for AMA Alternate Seat No. 6 by Dr. Eric F. Geiger, Chairman, Escambia County Medical Society Delegation.

A motion to elect Dr. Charles B. Kahn as AMA Alternate, Seat No. 6 carried unanimously.

AMA Alternate — Seat No. 7

The Speaker opened the floor for nominations for the AMA Alternate Seat No. 7.

Dr. James W. Walker, M.D., was nominated by Dr. Faris S. Monsour, President, Duval County Medical Society.

A motion to elect Dr. James W. Walker for AMA Alternate Seat No. 7 carried unanimously.

Judicial Council

The Speaker referred the House to the Report of the Board of Governors in which the Board had nominated Dr. Maurice Laszlo for election to the Judicial

Council from the membership at large for a five-year term expiring in 1986.

The nomination was adopted and Dr. Maurice Laszlo was elected.

Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report and asked for additional nominations from the floor. There being no nominations from the floor, it was moved and seconded that the nominees as proposed by the Board of Governors be elected to the Committee on Membership and Discipline. The motion carried.

District 1	Herbert E. Brooks, M.D. (85)
District 2	James K. Conn, M.D. (85)
District 3	Joe C. Ebbinghouse, M.D. (85)
District 4	Samuel K. Renfro, M.D. (85)
District 5	Frederick Weigand, M.D. (85)
District 6	Royce Hobby, M.D. (85)
District 7	Jeff W. Harris, M.D. (85)
District 8	James D. Morgan, M.D. (85)
District 9	Richard Neil Baney, M.D. (85)
District 10	Martin E. Mihm, M.D. (85)
District 11	Reginald J. Stambaugh, M.D. (85)
District 12	Robert J. Brennan, M.D. (85)
District 13	Maurice H. Laszlo, M.D. (85)
District 14	Richard M. Fleming, M.D. (85)
District 15	John D. White, M.D. (85)

Dr. Mullen announced the presidential appointments to the Board of Governors.

FPIR-82 — Vernon B. Astler, M.D.


HRS-82 — Eugene G. Peek Jr., M.D.

SBME-82 — Robert N. Webster, M.D.

Optional Member of Executive Committee —
Francis C. Coleman, M.D.

The Speaker resumed the Chair and called on Dr. William Davenport for the benediction.

The 1981 House of Delegates adjourned at 11:00 a.m.



ORGANIZATION

Impaired Physician Intervention Workshop In Tampa in September

The Florida Medical Foundation Committee on Impaired Physicians will present its second "Workshop on Intervention with Impaired Physicians" in Tampa in September.

The sessions will be held from 8:00 a.m. to 5:00 p.m. on Friday and Saturday, September 25-26, according to Guy T. Selander, M.D., of Jacksonville, Chairman of the Committee. The meeting will take place at the new Tampa Marriott Hotel, the purpose of the program is to train interested physicians in intervention techniques so that they will be able to confront alcohol or drug-impaired physicians on behalf of the Committee and guide them

into appropriate programs of treatment and rehabilitation.

The first intervention workshop was held last March in Miami under the direction of Dolores A. Morgan, M.D., Medical Director of the Impaired Physicians Program, and was quite successful, Dr. Selander said.

Complete information will be sent to county medical society and specialty group officers and executives as well as local impaired physician committees in the near future. Registration is subject to acceptance by the Committee.



Dr. Fogel

Bernard J. Fogel, M.D. . . . has assumed duties as Interim Vice President for Medical Affairs and Dean of the School of Medicine of the University of Miami. The appointment was effective June 1, the day following the retirement of **Emanuel M. Papper, M.D.**

Dr. Fogel has been associated with the School of Medicine for almost 25 years as a student, pediatric resident, faculty member

and Associate Dean for Medical Education, Admissions and Research. For the last seven years, he has served directly under Dr. Papper as Assistant Vice President and Assistant Dean.

A Professor of Pediatrics, Dr. Fogel collaborated with **William Cleveland, M.D.**, the Department Chairman, in performing the first successful Thymus transplant. In 1968, students elected him the School's Outstanding Teacher.

Sterling J. Edwards, Ph.D. . . . has been appointed Director of Development for the University of South Florida Medical Center in Tampa. A native of Tampa, Dr. Edwards attended Davidson College in North Carolina and earned his doctorate degree at the University of Edinburgh in Scotland.

Dr. Edwards assumed the Tampa position on June 1 after five years of service as Director of Planned Giving at the University of Alabama, Birmingham.



Dr. Elfenbein

Gerald J. Elfenbein, M.D. . . . 36-year-old immunology specialist, has been appointed Medical Director of the new bone marrow transplant unit at the University of Florida Health Center in Gainesville.

Dr. Elfenbein, whose most recent appointment was Assistant Director of the Johns Hopkins University's bone marrow transplant unit in Baltimore, Md., assumed the Florida position

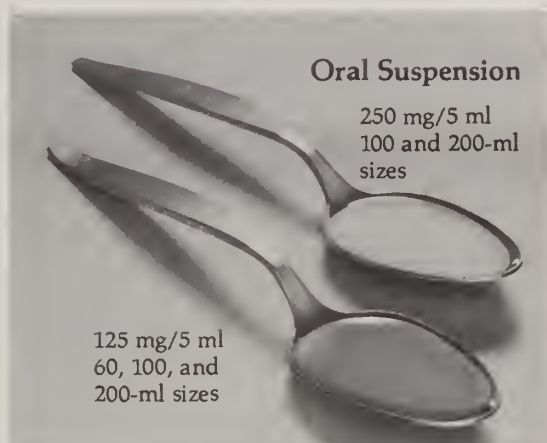
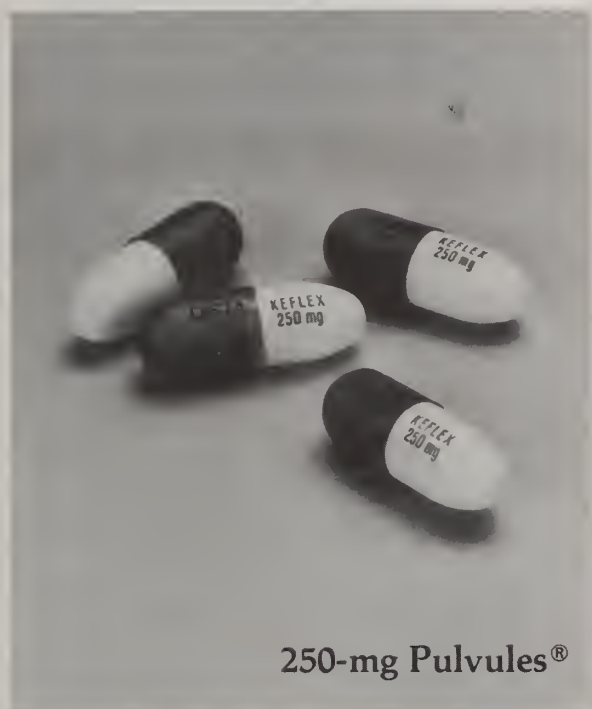
on July 11. He also became an Associate Professor of Medicine in the division of medical oncology at the University of Florida College of Medicine.

The transplant unit in Gainesville is the first of its kind in the Southeast. Dr. Elfenbein's research on the human body's immune system and related disease and therapy has been the subject of many journal articles and book sections.

The new Director received his medical training at the Johns Hopkins University School of Medicine.

Nine Florida physicians . . . have been elected Fellows to the American College of Physicians. Among those inducted at the College's Annual Session in April were: **M. Narayanan, M.D.**, of Arcadia; **Robert L. Drapkin, M.D.**, of Dunedin; **Mohan S. Khurana, M.D.**, of Englewood; **Jerome P. McCourt, M.D.**, of Fort Myers; **John L. Roque, M.D.**, of Jacksonville; **Alvin E. Smith, M.D.**, Ormond Beach; **Mitchell B. Lowenstein, M.D.**, Palm Harbor; and **Benedict S. Maniscalco, M.D.**, and **Robert J. Pollet, M.D.**, both of Tampa.

easy to take



Keflex®
cephalexin

Additional information available
to the profession on request.



Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment



**CONVENTION
PRESS, INC.**

2111 NORTH LIBERTY ST.

**JACKSONVILLE,
FLORIDA 32206**

PHONE 904/354-5555

This publication
is available
in microform.



University Microfilms International

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London W1N 7RA
England



PROFESSIONALLY CHALLENGING ... PERSONALLY REWARDING ... **FLORIDA**

SPECTRUM EMERGENCY CARE, dedicated to quality health care, is the leader in the management and staffing of over 220 emergency facilities in 33 states.

SPECTRUM currently offers opportunities throughout the STATE OF FLORIDA to qualified physicians who are seeking:

- * A guaranteed annual income - Production based bonus system.
- * Paid Professional Liability Insurance.
- * Flexible scheduling with regular hours; no on-call involvement.
- * Director and clinical positions; full and part-time opportunities.
- * Metropolitan and rural settings ... high and moderate annual patient visits.
- * Continuing medical education reimbursement; assistance with licensure expense.
- * Career growth potential.
- * Association with medical management experts in the emergency health care field.

Physician interviews are currently in progress. Inquiries are invited by contacting Mr. John Kutchback toll-free at 1-800-325-3982 or by forwarding credentials in complete confidence to Spectrum Emergency Care, Inc., 970 Executive Parkway, St. Louis, MO 63141.



FMA AUXILIARY

Fifteenth Annual Benefit Art Show Winners 1980 - 1981

YOUTH DIVISION

- 1 - 6**
1. George Francis Sullivan, Age 5, "George"
 2. Heather Hirsch, Age 6, "Daddy at the Barbecue"
- 7 - 12**
1. Karen Sedar, Age 9, "The Birds"
 2. Jennifer Hirsch, Age 9, "Florida Sunset"
- 13 - 18**
1. Kathy Tignor, Age 14, "Better Times"
 2. Francis Costantino, Age 17, "Forest and Mountains"
- Honorable Mention**
1. Alicia Costantino, Age 15, "Mountains"
- Special Crafts Award**
1. Joan Von Thron, Age 14, Stained Glass
- Youth Photo**
1. John Foley, Age 17, "The Mast"
 2. Margery Moore, Age 17

ADULT DIVISION

- Photo**
1. Mrs. Michael Foley (Dot) Black and White
 2. Mrs. Milton Tignor (Jo) Mardi Gras
- Honorable Mention**
1. Dr. C. Fenner McConnell "Reflections"
- Graphics**
1. Jane Grow "Nite Lite"
 2. Dr. John Freeman Jr. "Price of Victory"
- Honorable Mention**
- Frannie Mathews "Black Caped Lory"
- Special Crafts Award**
1. Marjorie Bean "Designs of Nature"
 2. Pam Boyd "Fine Feathered Friend"
- Painting**
1. Mrs. David Sneed (Jo) "Rural Central Florida"
 2. Marilyn Levine "Shells"
- Honorable Mention**
1. Patty Durfee "Quiet Foxes"
 2. Dr. Robert Pickard Chair Study
- Special Award for Outstanding Portraits**
1. Dr. Charles Harris "The Image of Rolf"
- Special Award**
1. Dr. Joel Levin for his Outstanding Pieces of Sculpture
- Editor's Award**
1. Dr. Lee Fischer "Trick or Treat"
- Best in Show, Youth Division**
1. Kathy Tignor, Age 14, "Better Times"
- Best in Show, Adult Division**
1. Mrs. David Sneed (Jo Ellen) "Rural Central Florida"

Alert and
functioning
in the
sunset
years

Treat the symptoms in
the geriatric patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule contains:

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



ENERGY IS EVERYTHING.

SAVE IT ON THE ROAD

Put the money into your
pocket, instead of your gas
tank.

When you waste energy on the road, you not only hurt your state and your country, you also hurt yourself and your family. Because you're literally burning up money that could be used for a lot of other worthwhile purposes.

Here are six ways you can save a lot of money and energy on the road.

1. Car pool. Van pool. Use public transportation. To work. To school. To wherever. By sharing the ride, you can save hundreds of dollars a year.
2. When starting up, accelerate briskly, and steadily, until you reach the proper cruising speed. You'll improve mileage.
3. Drive a car that won't eat you out of house and home. Select the most energy efficient car for your needs. Nobody expects gas prices to go down.
4. Keep your car and tires in shape. A tune-up, proper air pressure and changing oil at the right time can save money every mile you drive.
5. Streamline your truck by installing a cab-mounted wind deflector.
6. Send for Florida's tips on how to save money and energy on the road.

Write: Save it on the road, The Capitol, Tallahassee, Florida 32301.

In today's world, energy is everything. Save it on the road. Save it, Florida.



SAVE IT, FLORIDA.

This message brought to you by The Governor's Energy Partner.

MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, (7th Annual Review Course), Aug., Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

ECG Interpretation and Arrhythmia Management, August 28-30, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood 80112.

SEPTEMBER

Department of Surgery Meeting, Sept. 8, St. Joseph Hospital, Port Charlotte. For information: Jane P. Ontog, R.N., M.S., 601 N.E. Harbor Blvd., Port Charlotte 33952.

Indication and Implications of Office Pulmonary Function Testing, Sept. 17, Ft. Cooper Station Restaurant, Inverness. For information: C. J. McGrew Jr., M.D., 2875 Keysville Avenue, Spring Hill 33526.

OCTOBER

X-Ray Interpretation for the Primary Care and Emergency Physician, Oct. 1-4, St. Petersburg. For information: Sharon G. Llera, Administrative Assistant, Professional Services, Emergency Medical Services Assistants, 1400 66 Street, Suite 260, St. Petersburg 33710.

Parenting and Reparenting, Oct. 2, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Fort Walton Beach 32548.

Evaluation and Therapy of Shock and Drowning, Oct. 15, Ft. Myers. For information: Irwin J. Kash, M.D., Chairman, Department of Pediatrics, 3949 Evans Avenue, Suite 207, Ft. Myers 33901.

NOVEMBER

Clinical Management of Coronary Disease and Exercise Testing, Nov. 6-8, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood, CO 80112.

The ABC's of Viral Hepatitis, Nov. 19, Ft. Cooper Station Restaurant, Inverness. For information: C. J. McGrew Jr., M.D., 2875 Keyville Avenue, Spring Hill 33526.

**A peripheral
vasodilator
for treatment of
leg cramps
cold feet
tinnitus
discomfort on
standing**

LIPO-NICIN®
Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

Florida Medical Association, Inc.

Officers, Councils and Committees

1981-1982

OFFICERS

Sanford A. Mullen, M.D., President Jacksonville
 Robert E. Windom, M.D., President-Elect Sarasota
 Gerold L. Schiebler, Vice President Gainesville
 James B. Perry, M.D., Speaker/ of House Ft. Lauderdale
 Franklin B. McKechnie, M.D., Vice Speaker Winter Park
 Luis M. Perez, M.D., Secretary Sanford
 J. Russell Forlaw, M.D., Treasurer Boynton Beach
 T. Byron Thames, M.D., Imm. Past President Orlando
 W. Harold Parham, D.H.A., Exec. V.P. Jacksonville

BOARD OF GOVERNORS

Sanford A. Mullen, M.D., *Chm. and Pres. Jacksonville
 Robert E. Windom, M.D., *President-Elect Sarasota
 Gerold L. Schiebler, M.D., *Vice President Gainesville
 Luis M. Perez, M.D., *Secretary Sanford
 J. Russell Forlaw, M.D., *Treasurer Boynton Beach
 Richard S. Hodes, M.D., PP-82 Tampa
 T. Byron Thames, M.D., *IPP-83 Orlando
 James B. Perry, M.D., Speaker of House Ft. Lauderdale
 Francis C. Coleman, M.D., *AL-82 Tampa
 J. Lee Dockery, M.D., A-82 Gainesville
 Thomas E. McKell, M.D., B-83 Tampa
 Norman M. Kenyon, M.D., D-84 Miami
 Dick L. Van Eldik, M.D., C-85 Lake Worth
 Vernon B. Astler, M.D., **FPIR-82 Boynton Beach
 Eugene G. Peek Jr., M.D., HRS-82 Ocala
 Rufus K. Broadaway, M.D., AMA Del.-82 Miami
 Robert N. Webster, M.D., SBME-82 Tallahassee
 James E. Deming, Student Member-82 Miami

*Executive Committee

**Public Relations Officer

Liaison with Florida Osteopathic Medical Association

Louis C. Murray, M.D. Orlando

Liaison with Florida Bar

Robert E. Windom, M.D. Sarasota

Liaison with Allied Health Groups

Luis M. Perez, M.D. Sanford

Liaison with Blue Shield of Florida, Inc.

James B. Perry, M.D. Ft. Lauderdale

Liaison with Voluntary Health Agencies

Robert E. Windom, M.D. Sarasota

AMA HOUSE OF DELEGATES

James T. Cook, M.D., Delegate Seat #1 Marianna
 (Term expires 12/31/81)
 T. Byron Thames, M.D., Delegate Seat #1 Orlando
 (Term begins 1/1/82; expires 12/31/83)
 Vincent P. Corso, M.D., Alternate Seat #1 Miami
 (Term expires 12/31/83)
 Samuel M. Day, M.D., Delegate Seat #2 Jacksonville
 Luis M. Perez, M.D., Alternate Seat #2 Sanford
 (Terms expire 12/31/82)

Charles K. Donegan, M.D., Chm., Delegate Seat #3 ..St. Petersburg
 Francis C. Coleman, M.D., Alternate Seat #3 Tampa
 (Terms expire 12/31/82)
 Burns A. Dobbins, M.D., Delegate Seat #4 Ft. Lauderdale
 Eugene G. Peek Jr., M.D., Alternate Seat #4 Ocala
 (Terms expire 12/31/83)
 Richard G. Connar, M.D., Delegate Seat #5 Tampa
 Vernon B. Astler, M.D., Alternate Seat #5 Boynton Beach
 (Terms expire 12/31/82)
 Rufus K. Broadaway, M.D., Delegate Seat #6 Miami
 (Term expires 12/31/83)
 T. Byron Thames, M.D., Alternate Seat #6 Orlando
 (Term expires 12/31/81)
 *Charles B. Kahn, M.D., Alternate Seat #6 Hollywood
 (Term begins 1/1/82; expires 12/31/83)
 Joseph C. Von Thron, M.D., Vice Chm., Del. Seat #7...Cocoa Bch.
 (Term expires 12/31/83)
 William J. Dean, M.D., Alternate Seat #7St. Petersburg
 (Term expires 12/31/81)
 James W. Walker, M.D., Alternate Seat #7Jacksonville
 (Term begins 1/1/82; expires 12/31/83)

BOARD OF PAST PRESIDENTS

Henry J. Babers Jr., M.D., 1969, Chairman Gainesville
 T. Byron Thames, M.D., 1980, Secretary Orlando
 Walter C. Jones, M.D., 1941 Coral Gables
 Frederick K. Herpel, M.D., 1953 Laguna Hills
 Duncan T. McEwan, M.D., 1954 Orlando
 William C. Roberts, M.D., 1957 Panama City
 Jere W. Annis, M.D., 1958 Lakeland
 Ralph W. Jack, M.D., 1959 Miami
 Leo M. Wachtel, M.D., 1960 Jacksonville
 Warren W. Quillian, M.D., 1963 Coral Gables
 Samuel M. Day, M.D. 1964 Jacksonville
 H. Phillip Hampton, M.D., 1965 Tampa
 George S. Palmer, M.D., 1966 Tallahassee
 William D. Steward, M.D., 1967 Marianna
 Jack Q. Cleveland, M.D., 1968 Coral Gables
 Henry J. Babers Jr., M.D., 1969 Gainesville
 James T. Cook Jr., M.D., 1970 Marianna
 Floyd K. Hurt, M.D., 1971 Jacksonville
 William J. Dean, M.D., 1972 St. Petersburg
 Joseph C. Von Thron, M.D., 1973 Cocoa Beach
 Thad Moseley, M.D., 1974 Jacksonville
 Vernon B. Astler, M.D., 1975 Boynton Beach
 Jack A. MacCris, M.D., 1976 St. Petersburg
 Louis C. Murray, M.D., 1977 Orlando
 O. William Davenport, M.D., 1978 Miami
 Richard S. Hodes, M.D., 1979 Tampa

FMA SPEAKERS BUREAU

Edward R. Annis, M.D., Chairman Miami Shores
 O. William Davenport, M.D. Miami
 Joseph C. Von Thron, M.D. Cocoa Beach
 Robert E. Windom, M.D. Sarasota
 Vernon B. Astler, M.D. Boynton Beach
 J. Lee Dockery, M.D. Gainesville

Louis C. Murray, M.D. Orlando
 Jack A. MaCris, M.D. St. Petersburg
 T. Byron Thames, M.D. Orlando
 James W. Walker, M.D. Jacksonville
 Donald G. Nikolaus, M.D. Dunedin
 Richard S. Hodes, M.D. Tampa
 Philip B. Phillips, M.D. Pensacola

AD HOC COMMITTEE ON MANAGEMENT

Vernon B. Astler, M.D. Chairman Boynton Beach
 Sanford A. Mullen, M.D. Jacksonville
 Robert E. Windom, M.D. Sarasota
 T. Byron Thames, M.D. Orlando
 James B. Perry, M.D. Ft. Lauderdale

COUNCIL ON LEGISLATION

Louis C. Murray, M.D., Chairman Orlando
 Francis C. Coleman, M.D., Vice Chairman Tampa

NATIONAL LEGISLATION

Francis C. Coleman, M.D., Chairman Tampa
 Jere W. Annis, M.D. Lakeland
 Robert E. Windom, M.D. Sarasota
 Joe B. Harbison, M.D. Panama City
 Taylor H. Kirby, M.D. Gainesville
 Samuel M. Day, M.D. Jacksonville
 Eugene G. Peek Jr., M.D. Ocala
 Wm. F. Eckbert, M.D. Winter Park
 John M. Hamilton, M.D. St. Petersburg
 Irving M. Essrig, M.D. Tampa
 Karl P. Rolls, M.D. Sarasota
 Wm. J. Brouard, M.D. Melbourne
 H. Quillian Jones, M.D. Fort Myers
 Reginald J. Stambaugh, M.D. West Palm Beach
 James B. Perry, M.D. Ft. Lauderdale
 Julian H. Groff, M.D. N. Miami Beach
 Margaret Skinner, M.D. Miami
 Warren Lindau, M.D. Miami

STATE LEGISLATION

James G. White, M.D., Chairman Ormond Beach
 Kay K. Hanley, M.D. Clearwater
 Francis L. Howington, M.D. Ft. Myers
 David C. Lane, M.D. Ft. Lauderdale
 Robert C. Mumby, M.D. Orlando
 Mrs. Joseph T. Saiter Gulf Breeze
 Daniel L. Seckinger, M.D. Miami
 Paul W. Taylor, M.D. Vero Beach
 William W. Thompson, M.D. Ft. Walton Beach
 Thomas P. Wood, M.D. Tallahassee

COUNCIL ON HEALTH CARE FINANCING

Charles P. Hayes Jr., M.D., Chairman Jacksonville

RELATIVE VALUE STUDIES

Joel W. Mattison, M.D., Chairman Tampa
 Charles K. Donegan, M.D., Vice Chairman St. Petersburg
 John C. Fletcher, M.D. Tampa
 Laudie E. McHenry, M.D. Melbourne
 George A. Richard, M.D. Gainesville

AUTOMATED DATA SYSTEMS

H. Phillip Hampton, M.D., Chairman Tampa
 Paul F. Eckstein, M.D. Tampa
 Ralph R. Grams, M.D. Gainesville

ALTERNATIVE DELIVERY SYSTEMS

William J. Garoni Jr., M.D., Chairman Jacksonville
 Martin S. Feigenbaum, M.D. Ormond Beach
 Robert H. Hux, M.D. Leesburg
 William A. Sodeman Jr., M.D. Tampa

BUSINESS AND INDUSTRY RELATIONS

William T. Branch, M.D., Chairman Tampa
 Robert E. Boyett, M.D. Miami
 Faris S. Monsour, M.D. Jacksonville

COST EFFECTIVENESS

James F. Richards Jr., M.D., Chairman Orlando
 George H. McSwain, M.D. Daytona Beach

GOVERNMENT PROGRAMS

Frank B. Hodnette, M.D., Chairman Pensacola
 James K. Conn, M.D. Tallahassee
 Donald G. Nikolaus, M.D. Dunedin

HEALTH INSURANCE

Clarence M. Gilbert, M.D., Chairman Orlando
 James L. Borland Jr., M.D. Jacksonville
 James A. Montgomery, M.D. Jacksonville
 Franklin H. Pfeiffenberger, M.D. Sarasota
 Margaret H. Skinner, M.D. Miami

HEALTH PLANNING

Paul J. Popovich, M.D., Chairman Melbourne
 Richard A. Bagby, M.D. Tampa
 William M. Colmer, M.D. Pensacola
 Donald R. Hansard, M.D. Tallahassee
 Arthur Radin, M.D. Miami

PEER REVIEW ORGANIZATIONS

Charles P. Hayes Jr., M.D., Chairman Jacksonville
 John N. Carlson, M.D. Sarasota
 Jack W. MacDonald, M.D. Tallahassee

SUBCOMMITTEE ON PEER MEDICAL UTILIZATION REVIEW

Kenneth C. Kiehl, M.D., Chairman Sarasota
 Burns A. Dobbins Jr., M.D. Fort Lauderdale

WORKERS' COMPENSATION

James F. Richards Jr., M.D., Chairman Orlando
 Lawrence S. Cohen, M.D. Tampa
 C. Stanton Green, M.D. Jacksonville

COUNCIL ON MEDICAL SERVICES

Joseph T. Ostroski, M.D., Chairman Miami

EMERGENCY MEDICAL SERVICES

Roy Baker, M.D., Chairman.....	Jacksonville
Arthur L. Trask, M.D., Vice Chairman.....	Boynton Beach
H. Wayne Lee, M.D.	Ft. Lauderdale
Daniel E. Lucas, M.D.	Stuart
James L. Talbert, M.D.	Gainesville
Jim C. Hirschman, M.D.	Miami

DRUG ABUSE

Robert P. Johnson, M.D., Chairman.....	Tallahassee
Edward B. Jaffe, M.D.	N. Miami Beach
Donald I. Macdonald, M.D.	Clearwater
Donn L. Smith, M.D.	Tampa
Phineas J. Hyams, M.D.	Miami
W. Pearson Clack, M.D.	Sarasota

SCHOOL HEALTH

Wesley S. Nock, M.D., Chairman	Miami
Edward W. Stoner, M.D.	Oveido
Joseph E. Holland, M.D.	Leesburg

PUBLIC HEALTH

Patricia C. Cowdery, M.D., Chairman	Jacksonville
Clarence L. Brumback, M.D.	West Palm Beach
Robert D. May, M.D.	New Port Richey
George A. Gant, M.D.	Kissimmee
Wm. Farris Hill Jr., M.D.	Winter Haven

COUNCIL ON SCIENTIFIC ACTIVITIES

Yank D. Coble Jr., M.D., Chairman	Jacksonville
---	--------------

MEDICAL EDUCATION

Henry M. Yonge, M.D., Chairman	Pensacola
Calvin W. Martin, M.D., Vice Chairman	Arcadia
Jose S. Bocles, M.D.	Miami
Samuel E. Crockett, M.D.	Orlando
William B. Deal, M.D.	Gainesville
Bernard J. Fogel, M.D.	Miami
Ira B. Harrison, M.D.	Tallahassee
David S. Hubbell, M.D.	St. Petersburg
Orris O. Rollic, M.D.	Orlando
Andor Szentivanyi, M.D.	Tampa

SCIENTIFIC PUBLICATIONS

Daniel B. Nunn, M.D., Editor	Jacksonville
Clyde M. Collins, M.D., Associate Editor	Jacksonville
E. Charlton Prather, M.D., Associate Editor	Tallahassee
Francis C. Coleman, M.D., Assistant Editor	Tampa
James K. Conn, M.D., Assistant Editor	Tallahassee
Lee A. Fischer, M.D., Assistant Editor	West Palm Beach
Henry L. Harrell Jr., M.D., Assistant Editor	Ocala
Norman M. Kenyon, M.D., Rep. Board of Governors	Miami
Edward Pedrero Jr., M.D., Assistant Editor	Tampa
William M. Straight, M.D., Historical Editor	Miami
F. Norman Vickers, M.D., Book Review Editor	Pensacola

COUNCIL ON SPECIALTY MEDICINE

Arthur L. Eberly, M.D., Chairman	Lighthouse Point
--	------------------

Florida Allergy Society Melvin Newman, M.D.	Jacksonville
Florida Society of Anesthesiologists Warren H. Rossway, M.D.	Vero Beach
Florida Chapter, American College of Chest Physicians Larry J. Foster, M.D.	Tampa
Florida Society of Colon and Rectal Surgeons Harvey A. Shub, M.D.	Orlando
Florida Society of Dermatology Lawrence T. Wagers, M.D.	Winter Park
Florida Chapter, American College of Emergency Physicians Fredrick C. Wurtzel, M.D.	Maitland
Florida Endocrine Society Andrew J. Scoma, M.D.	Maitland
Florida Academy of Family Physicians Joseph C. Von Thron, M.D.	Cocoa Beach
Florida Gastroenterologic Society John J. Kennedy, M.D.	Orlando
Florida Society of Internal Medicine Arthur L. Naddell, M.D.	Ft. Lauderdale
Florida Society of Neonatal Perinatologists Jeane A. McCarthy, M.D.	St. Petersburg
Florida Society of Nephrologists Michael J. Pickering, M.D.	Tampa
Florida Society of Neurology John S. Scott, M.D.	Orlando
Florida Neurosurgical Society William E. Hoffmeister, M.D.	Winter Park
Florida Association of Nuclear Physicians Fuad S. Ashkar, M.D.	Miami
Florida Obstetric and Gynecologic Society John E. Startzman, M.D.	Orlando
Florida Occupational Medical Association Frederick C. Andrews, M.D.	Mount Dora
Florida Society of Clinical Oncologists Thomas G. Sawyer, M.D.	Orlando
Florida Society of Ophthalmology Alfred S. Jolson, M.D.	Winter Park
Florida Orthopedic Society William J. Hutchison, M.D.	Tallahassee
Florida Society of Otolaryngology J. Andrew Burnam, M.D.	Miami
Florida Society of Pathologists Wayne H. Schrader, M.D.	Orlando
Florida Chapter, American Academy of Pediatrics and Florida Pediatric Society Thomas H. Greiwe, M.D.	Tampa
Florida Association of Pediatric Cardiologists Ira H. Gessner, M.D.	Gainesville
Florida Association of Pediatric Surgeons Ronald F. David, M.D.	Orlando
Florida Society of Physical Medicine and Rehabilitation Richard A. Chidsey, M.D.	North Palm Beach
Florida Region, American College of Physicians David A. Giordano, M.D.	Sarasota
Florida Society of Plastic and Reconstructive Surgery John Royer, M.D.	Winter Park
Florida Society for Preventive Medicine E. Charlton Prather, M.D.	Tallahassee
Council of Florida District Branches, American Psychiatric Society McKinley Cheshire, M.D.	West Palm Beach
Florida Radiological Society Donald Q. Vining, M.D.	Naples
Florida Society of Rheumatology Louis M. Sales, M.D.	Jacksonville
Florida Chapter, American College of Surgeons John C. Fletcher, M.D.	Tampa

Florida Association of General Surgeons

William H. Meyer Jr., M.D. Ft. Pierce

Florida State Surgical Division, International

College of Surgeons

Julian A. Rickles, M.D. Miami Beach

Florida Society of Thoracic and Cardiovascular Surgeons

Robert B. Trumbo, M.D. Orlando

Florida Thoracic Society

Robert C. Snyder, M.D. Orlando

Florida Urological Society

Truett H. Frazier, M.D. Orlando

JUDICIAL COUNCIL

James A. Winslow Jr., M.D., B-84, Chairman Tampa

Maurice H. Laszlo, M.D., AL-86 North Miami Beach

O. Frank Agee, M.D., A-85 Gainesville

Robert J. Brennan, M.D., C-83 Ft. Lauderdale

Joseph H. Davis, M.D., D-82 Miami

MEMBERSHIP AND DISCIPLINE

Ray E. Murphy Jr., M.D., Chairman Deerfield Beach

District 1 — Lealis L. Hale Jr., M.D., 82 Ft. Walton Beach

Charles F. McConnell, M.D., 83 Pensacola

Robert D. Palmer, M.D., 84 Port Charlotte

Herbert E. Brooks, M.D., 85 Bonifay

District 2 — James M. Dell Jr., M.D., 82 Gainesville

Robert P. Johnson, M.D., 83 Tallahassee

James T. Cook Jr., M.D., 84 Marianna

James K. Conn, M.D., 85 Tallahassee

District 3 — Samuel A. Alford Jr., M.D., 82 Jacksonville

Hugh A. Carithers, M.D., 83 Jacksonville

John A. Rush, M.D. 84 Jacksonville

Joe C. Ebbinghouse, M.D., 85 Jacksonville

District 4 — Martin Pepus, M.D., 82 Daytona Beach

Edwin H. Updike, M.D., 83 Ocala

Richard W. Snodgrass, M.D. 84 Daytona Beach

Samuel L. Renfroe, M.D., 85 Ocala

District 5 — John L. Geeslin, M.D., 82 Eustis

Frank C. Bone, M.D., 83 Orlando

Frederick C. Andrews, M.D., 84 Mount Dora

Frederick J. Weigand, M.D., 85 Deltona

District 6 — James C. Fleming, M.D., 82 Dunedin

David T. Overbey, M.D., 83 St. Petersburg

John T. Karaphillis, M.D., 84 Clearwater

Royce Hobby, M.D., 85 St. Petersburg

District 7 — J. Robert Qualey, M.D., 82 Tampa

Linus W. Hewit, M.D., 83 Tampa

William B. Hopkins, M.D., 84 Tampa

Jeff W. Harris, M.D., 85 Tampa

District 8 — Thomas R. Busard, M.D., 82 Bradenton

Ernest P. Palmer, M.D., 83 Wauchula

Wiley E. Koon, M.D., 84 Winter Haven

James D. Morgan, M.D., 85 Winter Haven

District 9 — Francis S. Pooser, M.D., 82 Melbourne

Franklin B. McKechnie, M.D., 83 Winter Park

Clarence M. Gilbert, M.D., 84 Orlando

Richard Neil Baney, M.D., 85 Melbourne

District 10 — Martin F. Mim, M.D., 81 Sarasota

Fred S. Carter, M.D., 82 Jensen Beach

John N. Sims, M.D., 83 Ft. Pierce

Douglas R. Murphy, M.D., 84 Venice

District 11 — Luis R. Guerrero, M.D., 82 Belle Glade

John D. Corbitt Jr., M.D., 83 Lake Worth

Ray E. Murphy Jr., M.D., 84 Deerfield Beach

Reginald J. Stambaugh, M.D., 85 W. Palm Beach

District 12 — Peter A. Tomasello, M.D., 82 Plantation

John I. Williams, M.D., 83 Ft. Lauderdale

Anthony J. Vento, M.D., 84 Plantation

Robert J. Brennan, M.D., 85 Ft. Lauderdale

District 13 — Sheldon Zane, M.D., 82 N. Miami Beach

John G. Maclure, M.D., 83 N. Miami Beach

Arthur W. Wood Jr., M.D., 84 Punta Gorda

Maurice H. Laszlo, M.D., 85 N. Miami Beach

District 14 — Chester Cassel, M.D., 82 Miami

Robert J. Schiess, M.D., 83 Miami

Rufus K. Broadaway, M.D., 84 Miami

Richard A. Fleming, M.D., 85 Miami Beach

District 15 — Norman L. Gottlieb, M.D., 82 Miami

Sol Colsky, M.D., 83 Miami

Norman M. Kenyon, M.D., 84 Miami

John D. White, M.D., 85 Tavernier

FLORIDA MEDICAL ASSOCIATION AUXILIARY

Mrs. Frank Coleman, President Tampa

Mrs. Daniel Nunn, President-Elect Jacksonville

Mrs. Laurin G. Smith, First Vice President Orange Park

Mrs. N. Harry Carpenter, Secretary Ft. Lauderdale

Mrs. Milton Tignor Jr., Treasurer North Palm Beach

FLORIDA MEDICAL FOUNDATION

Eugene G. Peek Jr., M.D., President Ocala

T. Byron Thames, M.D., Vice President Orlando

Norman M. Kenyon, M.D., Vice President Miami

J. Lee Dockery, M.D., Vice President Gainesville

W. Harold Parham, D.H.A., Secretary Treasurer Jacksonville

CONTINUING MEDICAL EDUCATION

Robert H. Threlkel, M.D., Chairman Jacksonville

Robert E. Cline, M.D. Ft. Lauderdale

Eugene T. Davidson, M.D. Lakeland

Richard W. Dodd, M.D. Daytona Beach

Arvey I. Rogers, M.D. Miami

Yank D. Coble Jr., M.D. Jacksonville

Henry M. Yonge, M.D. Pensacola

PEER MEDICAL UTILIZATION REVIEW

Kenneth C. Kiehl, M.D., Chairman Sarasota

Burns A. Dobbins Jr., M.D., Vice Chairman Ft. Lauderdale

Ralph C. Aye, M.D. Tampa

John C. Dyal Jr., M.D. Perry

Frank D. Hodnette, M.D. Pensacola

John T. Karaphillis, M.D. Clearwater

Milton E. Lesser, M.D. Miami Beach

Willard E. Manry Jr., M.D. Lake Wales

Charles D. Mutter, M.D. Miami
 Elwin G. Neal, M.D. Miami Shores
 Benjamin C. Olliff, M.D. Jacksonville
 Peter A. Tomasello, M.D. Plantation

IMPAIRED PHYSICIANS

Guy T. Selander, M.D., Chairman Jacksonville
 Theodore J. Marshall, M.D. Pensacola
 Arvey I. Rogers, M.D. Miami
 John M. Butcher, M.D. Sarasota
 Mrs. Frederick J. Weigand Deltona

FLORIDA PHYSICIANS' INSURANCE RECIPROCAL

Directors (Advisory Committee)

Vernon B. Astler, M.D. Boynton Beach
 Jack A. MaCris, M.D. St. Petersburg
 O. William Davenport, M.D. Miami
 Richard S. Hodes, M.D. Tampa
 T. Byron Thames, M.D. Orlando

Attorney-in-Fact

W. Harold Parham, D.H.A. Jacksonville

PIMCO

W. Harold Parham, D.H.A., Chairman Jacksonville
 James W. Walker, M.D., President Jacksonville
 W. E. Addy, Vice President/Secretary Jacksonville
 William M. Howard, Ph.D., Vice President Gainesville
 Bruce A. Woolery, Vice President Woodside, CA.
 J. Edgar Cowart, Vice President/Treasurer Jacksonville
 Jerome S. Fletcher, Vice President Jacksonville

FLORIDA MEDICAL POLITICAL ACTION COMMITTEE

Board of Directors

Francis C. Coleman, M.D., President Tampa
 William W. Thompson, M.D., Immed. Past Pres. Ft. Walton Beach
 John M. Hamilton, M.D., Vice President St. Petersburg
 Reginald J. Stambaugh, M.D., Secretary West Palm Beach
 Louis C. Murray, M.D., Treasurer Orlando
 Robert E. Windom, M.D., Rep., FMA Board of Gov. Sarasota
 Carlos G. Llanes, M.D. Miami
 Juan S. A. Wester, M.D. Hollywood
 Mrs. B. D. Epstein, Rep, Auxiliary Miami

Assistant Treasurer

W. Harold Parham, D.H.A. Jacksonville

FLORIDA PHYSICIANS ASSOCIATION

David T. Overbey, M.D., President St. Petersburg
 John A. Dyal, M.D., Vice President Perry
 Warren M. Barrett, M.D., Secretary Jacksonville
 H. Quillian Jones Jr., M.D., Treasurer Ft. Myers
 James T. Cook Jr., M.D., Immed. Past Pres. Marianna

FLORIDA HEALTH DATA CORPORATION

FMA Representatives

James L. Borland Jr., M.D. Jacksonville
 David R. Stutz, M.D. Sarasota
 Chauncey M. Stone, M.D. Miami
 H. Phillip Hampton, M.D. Tampa

Alternates

Robert J. Schiess, M.D. Miami

JOINT UNDERWRITERS ASSOCIATION

FMA Representatives

Robert J. Brennan, M.D., Representative Ft. Lauderdale
 William J. Dean, M.D., Alternate St. Petersburg

PATIENTS COMPENSATION FUND

FMA Representatives

C. Stanton Green, M.D., Representative Jacksonville
 Mr. John Thrasher, Alternate Jacksonville

LEGAL COUNSEL

Mr. John Thrasher, J.D. Jacksonville

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

MEDICAL OPHTHALMOLOGIST wanted for busy practice. No refraction or contact lens fitting. Ideal location in East Coast of Florida. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

WELL TRAINED Family Practitioner or Internist needed to join staff of a Family Medical Center in Jacksonville, Florida. Excellent opportunity for professional and economic growth. Respond with CV to: Susan Masterson, Emergency Medical Services Associates, Inc., 8200 W. Sunrise Boulevard, Building C, Plantation, Florida 33322, or phone (305) 472-6922.

FLORIDA — Aggressive group, fee-for-service, malpractice, group health insurance, teaching, EMS, opportunity for advancement. Contact Steve Watsky, M.D., 707 40th Street West, Palmetto, Florida 33561, (813) 722-1722 or P. Fagan Jr., M.D., Post Office Box 9639-FL, Marina Del Rey, California 90291, (213) 822-1312.

LOCUM TENENS — COMP-HEALTH. Our medical group can provide a well qualified physician to cover your practice in your absence. For information, please write or call T.C. Kolff, M.D., Comprehensive Health Systems, Inc., 175 West 200 South, Suite 2003, Salt Lake City, Utah 84101, (801) 532-1200.

EMERGENCY MEDICINE opportunities throughout Florida: Directorship and clinical positions available to career-oriented emergency physicians in central and coastal areas. Excellent compensation, paid professional liability insurance, flexible scheduling to be awarded to physicians chosen. For details send credentials in complete confidence to Mary Obsitnik, 9100 Purdue, Suite 119, Indianapolis, IN 46268; or call collect (317) 875-7518.

INTERNIST TO JOIN established partnership practice, Orlando, Florida. Starting July 1981. Curriculum vitae to Internal Medicine Group, 1910 N. Orange Avenue, Orlando, Florida 32804.

FLORIDA — Pediatrician, must be Board certified — eligible, to associate with a busy, progressive practice, with excellent hospitals. Attractive and recreational area of Winter Park, and Orlando. Applicants are encouraged to submit a curriculum vitae to: Louis Spinelli, M.D., 100 Perth Lane, Winter Park, Florida 32792.

FP's NEEDED for ideally located office in north Palm Beach County, (Jupiter-Tequesta area). Also, space for ophthalmologist or dermatologist. Coverage and assistance available. Two open staff hospitals nearby for qualified M.D.'s. Call: (305) 746-2033.

TEMPORARY ADJUNCT RESEARCH ASSOCIATE — M.D. or Ph.D. with major emphasis on research in Tumor Biology. Experience must include sterile tissue culture techniques, isolation and characterization of T-cell clones, and biochemical techniques for the isolation and characterization of growth factors. Salary is negotiable with starting date of August 1, 1981. Forward applications by deadline of July 25, 1981 to: Edward K. Wakeland, Ph.D., Assistant Professor, Dept. of Pathology, Box J-275, JHMC, University of Florida, Gainesville, Florida 32601. An Equal Employment Opportunity/Affirmative Action Employer.

DERMATOLOGIST — Excellent opening. No dermatologist in this town.

Retirement area Coastal Southwest Florida. Reply: Post Office Box 1303, Englewood, Florida 33533.

FAMILY PRACTITIONER, GENERAL INTERNIST, Pulmonary internist board certified to join multi-specialty group practice on west coast of Florida. Excellent salary leading to partnership. Send C.V. to Michael T. Gossman, Community Health Center, 1150 Plaza Drive, New Port Richey, Florida 33553.

PHYSICIAN WANTED to share office space with Family Practitioner. Well equipped and centrally located in West Broward County. Reply: C-1058, Post Office Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN OR INTERNIST wanted to associate with young B/C Internist in rapidly growing area in Southwest Florida. Contact G. Gidseg, M.D., 130 Lee Boulevard, Lehigh Acres, Florida 33936.

ORTHOPEDIC SURGEON preparing to retire and now limiting practice and referring surgery. Opportunity for young orthopedist to start practice with no capital investment. In office across the street from St. Vincent's Medical Center. John Q. U. Thompson, M.D., 2561 Riverside Avenue, Jacksonville, Florida 32204. Telephone (904) 388-4671 or 398-7404.

FT. LAUDERDALE — Primary Care Facility actively recruiting ambitious physician. 40 hour week. Salary good. Ample time off. call (305) 474-4403.

NEUROLOGIST — We are a 200 bed private hospital seeking a board certified neurologist interested in establishing a practice with us. Please forward resume to the attention of Personnel, Horizon Hospital, 11300 U.S. Hwy. 19 South, Clearwater, Florida 33516.

CHATTANOOGA, TENNESSEE — New Hospital recruiting one Family Practitioner, and one E. R. Physician to join established groups. Two additional Family Practitioners needed to develop a group

practice in an under-doctored community (unique financial opportunity). One full-time Anesthesiologist needed for hospital (salary negotiable). All applicants must be board eligible, or certified for the above positions. If you want seasonal changes, excellent schools, a very low cost of living, and be close to Atlanta, Nashville, or the Smokey Mountains, this is an excellent opportunity. Please send your curriculum vitae with references to: C-1059, Post Office Box 2411, Jacksonville, Florida 32203.

MOORE HAVEN, FLORIDA — Population 4,000 (area). Agricultural — cattle; on Lake Okeechobee; nearest hospital is 15 miles away; no private physician. Call (813) 946-1212.

ANESTHESIOLOGIST — Tremendous solo practice opportunity is now available in the Tampa Bay region. The opportunity in this acute-care med/sur hospital involves separate billing and rotating call. American graduates contact: Carol Nussbaum, Humana Inc., Post Office Box 1438, Louisville, KY 40201 or call toll-free 1-800-626-1590.

CARDIOLOGIST — Group, solo, and associate private practice opportunities are available immediately in St. Petersburg, Ft. Walton, Pompano Beach and Sebastian, Florida. If you are an American graduate and interested in learning more specifics about any of these excellent opportunities contact: Carol Nussbaum, Humana Inc., Post Office Box 1438, Louisville, KY 40201 or call toll-free 1-800-626-1590.

MEDICAL DIRECTOR — Seminole County Mental Health Center seeks boarded or board eligible psychiatrist with a commitment to community mental health. Responsible for assessment and treatment in a comprehensive center including outpatient, emergency services, and inpatient psychiatric facility. Additional responsibilities include staff training and development and consultation with inter-disciplinary treatment teams. Salary commensurate with experience. Submit vitae to: Personnel Department, Seminole County Mental Health Center, Suite 377, Crane's Roost Office Park, Altamonte Springs, Florida 32701.

Situations Wanted

GENERAL, COLON AND RECTUM SURGEON, trained in Colonoscopy, Board eligible, 35, seeks position in Florida to practice either one specialty or both. Speaks Spanish fluently. Available October 1981. Contact: Luis F. Espallat, M.D., 1517 Texas Avenue, Homestead AFB, Florida 33039. Phone (305) 257-2870.

MEDICAL OPHTHALMOLOGY: 43 year old American Board certified, desires satisfactory position in established practice. Will consider all locations. Curriculum Vitae on request. C-1051, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON, 34, Broad experience, excellent references, relocating to Florida. Seeks immediate practice opportunities leading to partnership with group/solo practice. Particularly interested in combined Internal Medicine/Surgery practice. Prefer medically underserved area. Available August 1981. Reply: S. E. Katz, M.D., c/o Rohr, 319 East 53rd Street, New York, New York 10022, (212) 759-2631.

UNIVERSITY TRAINED GENERAL SURGEON who will finish a fellowship in Vascular Surgery on July 31, 1982; after which will be available for practice in both General/Vascular Surgery. Send reply to: Ruben Delgado, M.D., Spring Ridge M-26, Whitehall, PA 18052.

BOARD CERTIFIED (AP & CP). Experienced. Seeking the position of hospital based associate or assistant pathologist in the Florida State. Available immediately. Contact: C-1060, Post Office Box 2411, Jacksonville, Florida 32203.

ADULT AND PEDIATRIC UROLOGIST — 38-year-old Board certified Florida native, experienced in fertility and microsurgery seeks partnership, group or solo practice. Reply: C-1061, P.O. Box 2411, Jacksonville, Florida 32203.

Practices Available

GENERAL PRACTICE FOR SALE, growing area, Pinellas County; same location 20 years; also, possible association. Gonzalez, M.D., (813) 443-2104 after 7

p.m. or write P.O. Box 1286, Clearwater, Florida 33517.

GENERAL PRACTICE — Ft. Myers, Florida. Chance of a lifetime. Lucrative established practice for sale. Well equipped newly decorated office in professional building centrally located in rapidly expanding growth city. (813) 482-6779 or reply C-1062, Post Office Box 2411, Jacksonville, Florida 32203.

OTOLARYNGOLOGY PRACTICE — for sale. Active practice in Key West. Fully equipped, for 25% of annual gross. Entering Academics, if practice sells. Contact: William Clark, M.D. (305) 294-6622 or 296-2705.

WANTED FAMILY PRACTITIONER or Internist for 2,500 square foot clinic on Coral Way, west of the Palmetto expressway. Clinic fully equipped. Price includes practice, building and furnishings. Low down payment. Good tax shelter. Phone (305) 888-5335.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

LAKELAND, FLORIDA. Medical office space available in Professional Village; central Florida location. Colleges, retirement community, and industries create interesting environment for practice. 1424 square feet, can be partitioned to suit. Available as rental or purchase as condominium. Contact Edwin R. Lamm, M.D., (813) 682-3672 or 682-8124.

WEST PALM BEACH: Located in a new, fast developing area, 200 yards east of I-95 exit, adjoining The Community Hospital of the Palm Beaches and near St. Mary's hospital. Medical Suites: From 3 to 6 examining rooms, business office, waiting room, and consultation rooms. Storage closets, built-in office desk cabinets, multi drawer work area cabinet with sink, wash basins in each examining room, extensive parking. Contact: Community Professional

Building, 2151 45th Street, West Palm Beach, Florida 33407. (305) 842-5023.

TO SUBLET — Medical office space in prime Medical Office Building. Convenient to St. Joseph's and Women's Hospital, 4700 N. Habana Avenue, Tampa, Florida; 15550 square feet, well partitioned office, four exam rooms, two consultation rooms, lab and business office. Suitable for almost any specialty. Call (813) 877-7434.

OUTSTANDING LOCATION — Professional office space for rent. Multi-specialty building adjacent to modern 225 bed Medical Center emergency room. Contact Post Office Box 4082, Fort Pierce, Florida 33454. Phone: (305) 465-7060.

Equipment

ONE COLPOSCOPE — D.F. Vasconcellos top of line model — like new. Two used steel examination tables in good condition. Cryosurgical unit. Call: (813) 683-9393 Lakeland.

REMODELING? RETIRING? NEW physician looking for used office furniture, exam table and equipment to set up part-time practice in adolescent medicine and psychiatry. Contact R. S. Smith, M.D., Box 606, Ocala, Florida 32678, (904) 629-8893.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Col, 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Services

DOCTOR, WE KNOW YOUR BUSINESS. With 27 years experience as a hospital administrator and being raised in a Doctor Family, Bill Bishop, FACHA, understands your needs! He specializes in

recruitment and placement of doctors in Florida. Bill Bishop and Associates, Inc., Health Care Executive and Physician Search Consultant, 1045 Riverside Ave., Jacksonville, Florida 32204, (904) 354-1050.

Meetings

SNOWMASS / VAIL "MEP" SKI SEMINAR on Management Enrichment for the Health Professional. Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or Ski Vail, Colorado the week of February 20, 1982.

Seminars conducted by noted doctors and management specialists to enrich your life. Seminars comply with IRS rules to make trip expenses deductible for doctor and spouse. For brochure and lodging information contact: M.E.P., An Education Corporation, 906 Cooper Avenue, Glenwood Springs, Colorado 81601; or call (800) 525-3402.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Medical Decorators

**NEW OR EXISTING SPACE
PROFESSIONALS WORKING
AROUND YOUR SCHEDULE**

**(305) 772-0090
By Appointment**

**CARY MARTIN
5055 N.E. 13 Ave.
Fort Lauderdale, Fla. 33334**

Advertisers

Brown Pharmaceuticals		Micro Technique, Inc.	
Cerebro-Nicin	592	Service	489
Lipo-Nicin	593	National Medical Enterprises	
Android	489	Service	484
Burroughs Wellcome		Spectrum Emergency Care, Inc.	
Empirin \bar{c} Codeine	505	Service	590
Zyloprim	508	Reed & Carnrick	
Convention Press		Dilatrate-SR.	586a
Service	590	Roche Laboratories	
Cary Martin		Valium	472
Decorating	601	Limbitrol	603
DAC Corporation		University of Florida	
Service	508	Meeting	483
Florida Medical Foundation		University of Miami	
Fruit	506	Meetings	483, 490
Florida National Banks		Wetzel	
Service	506	Service	486
Geriatric Pharmaceutical Co.		Willingway Hospital	
Menic	480	Service	480
Eli Lilly & Company		Wyeth Laboratories	
Keflex	589	Cyclapen-W	476
Mead Johnson		Ativan	485
Klotrix	507	Eguagesic	490a
Leasing Services of Florida		Wygesic	490a
Service	483		

Florida Medical Association Officers and Council Chairmen

Officers

Sanford A. Mullen, M.D., Jacksonville, President
 Robert E. Windom, M.D., Sarasota, President-Elect
 Gerold L. Schiebler, M.D., Gainesville, Vice President
 Luis M. Perez, M.D., Sanford, Secretary
 J. Russell Forlaw, M.D., Boynton Beach, Treasurer
 T. Byron Thames, M.D., Orlando, Immediate Past-President
 James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
 Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
 W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
 Louis C. Murray, M.D., Orlando, Legislation
 Charles P. Hayes, M.D., Jacksonville, Health Care Financing
 Joseph T. Ostroski, M.D., Miami, Medical Services
 Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
 Arthur L. Eberly, M.D., Lighthouse Point, Specialty Medicine



AUGUST 1981 • VOL 68 • NO 8



Historical Issue

William M. Straight, M.D.
Historical Editor

LLS

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

SEP 4 1981

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases “overmedicated society,” “overuse,” “misuse,” and “abuse,” my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you’ve made. Recall how often you’ve heard, as a result, “Doctor, I don’t know what I would have done without your help.”

You and I can feel proud of what we’ve done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you’ll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/Roche)® , please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in savari studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

PROFIT FROM OUR EXPERIENCE

For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

We specialize in attaining the results that you require from your account in the areas of:

● **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.

● **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.

● **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

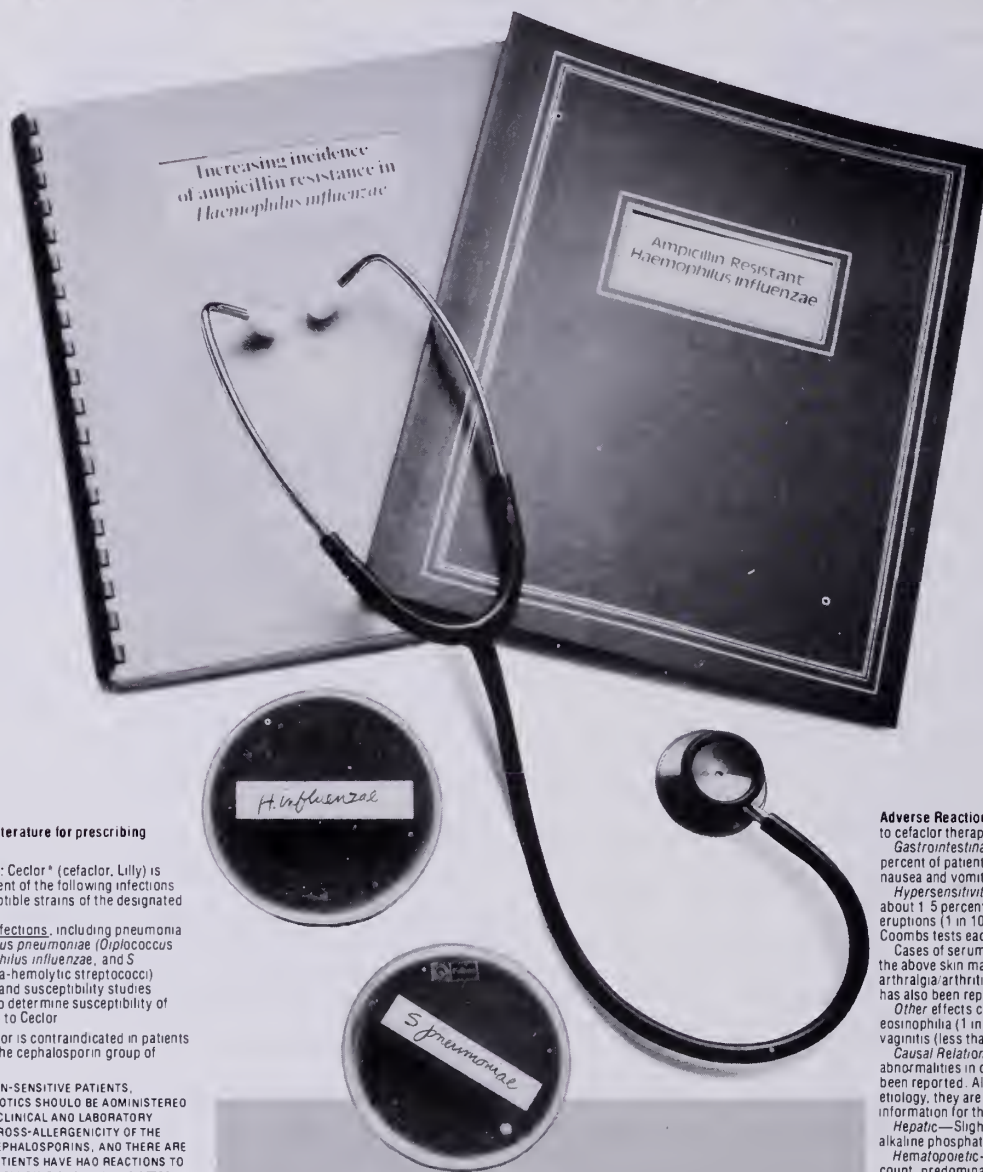
PEOPLE WHO KNOW HOW.

**Florida National
Trust Services**

214 Hogan Street
Jacksonville, Florida 32231
Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[103080R]

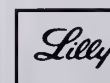
*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor® (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630

100361



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

AUGUST 1981 • VOL 68 • NO. 8 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.

E. Charlton Prather, M.D.

Assistant Editors

Francis C. Coleman, M.D.

James K. Conn, M.D.

Lee A. Fischer, M.D.

Henry L. Harrell Jr., M.D.

Norman M. Kenyon, M.D.

(from Board of Governors)

Edward Pedrero Jr., M.D.

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Susan L. Milhoan

Consulting Editorial Staff

Fuad S. Ashkar, M.D.	Karl J. Kramer, M.D.
Thomas D. Bartley, M.D.	R. G. Lacsamana, M.D.
Robert L. Batey, M.D.	Richard F. Lockey, M.D.
Pierre J. Bouis Jr., M.D.	Philander D. Morgan, M.D.
Ms. Deborah B. Wilbur	George Morris, M.D.
William T. Branch, M.D.	George A. Neder Jr., M.D.
Miguel A. Brito, Jr.	Richard S. Panush, M.D.
Elmer B. Campbell, M.D.	R. A. Penalver, M.D.
Manuel L. Carbonell, M.D.	John K. Petrakis, M.D.
Ronald W. Case, M.D.	Phillip B. Phillips, M.D.
Toni Charneco	Michael R. Redmond, M.D.
Louis E. Cimino, M.D.	Albert L. Rhoton, M.D.
Charles Craig, M.D.	James F. Richards Jr., M.D.
R. Jay Cummings Jr., M.D.	Arvey I. Rogers, M.D.
Raul deVelasco, M.D.	William J. Romanos Jr., M.D.
James E. Deming	Lees M. Schadel, M.D.
Pablo Enriquez, M.D.	Frederick W. Schert, M.D.
Robert F. Feltman, M.D.	Guy T. Selander, M.D.
Richard Feinstein, M.D.	Roberto A. Sosa, M.D.
Lawrence M. Fishman, M.D.	John Stone, M.D.
Allan L. Goldman, M.D.	Robert H. Threlkel, M.D.
Henry L. Harrell, M.D.	Benjamin E. Victorica, M.D.
Allan Herskowitz, M.D.	Thomas M. Wiley, M.D.
James T. Howell, M.D.	Charles D. Williams, M.D.
Rubin Klein, M.D.	Frederic C. Wurtzel, M.D.

Subscription Rate: \$15.00 per year, single copy. \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

Special History Issue

- 623 Introduction by Historical Editor
William M. Straight, M.D.
- 624 Prehospital Mobile Emergency Care in Miami, Florida,
An Historical Commentary
Jim C. Hirschman, M.D., and Eugene L. Nagel, M.D.
- 635 Pensacola's Early Hospitals
Elizabeth D. Vickers
- 644 Florida and the Spanish Flu
William M. Straight, M.D.

Special Articles

- 655 Excellence in Medicine:
A Rewarding Pursuit
Michael E. DeBakey, M.D.
- 657 Bad Hospital PR—The Patient Pays
F. Norman Vickers, M.D.
- 658 Hospital Privileges:
Who Should Have Them?
R. G. Lacsamana, M.D.

Editorial

- 619 Here We Go Again
James K. Conn, M.D.

Departments

- 613 President's Page
Medicine and History
Sanford A. Mullen, M.D.
- 659 Correspondence
- 659 Medical News Around the State
- 661 FMA Auxiliary
FMA Auxiliary News Capsules
- 664 Book Reviews
- 666 Books Received
- 668 Deaths
- 670 Meetings
- 675 Classified Advertising
- 678 Index to Advertisers
- 678 FMA Officers and Council Chairmen

Cover

The first rescue vehicle designed to facilitate the activities of emergency rescue workers was developed in Miami. The vehicle, was a stock recreational van which was customized. The development of mobile emergency care is traced beginning on page 624.

UNIVERSITY OF MIAMI
SCHOOL OF MEDICINE

TUTORIAL COURSES OF
INSTRUCTION IN
CORONARY CARE

Director: Louis Lemberg, M.D.
Co-Directors: Kyriacos Pefkaros, M.D.
Robert J. Myerburg, M.D.

SCHEDULE OF COURSES

1981

August 3-8
September 14-19
October 26-31
December 7-12

1982

January 18-23
February 15-20
March 8-13
March 29-April 3
June 14-19

(For more information please call (305) 325-6411 or complete coupon and mail to: M. Enriquez, Division of Cardiology (D-39), University of Miami School of Medicine, Post Office Box 016960, Miami, Florida 33101).

Please send me more information regarding
Tutorial Courses of Instruction in Coronary Care

Name _____

Phone () _____

Address _____

Zip _____

CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Branchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the Indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with **Renal Failure** Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

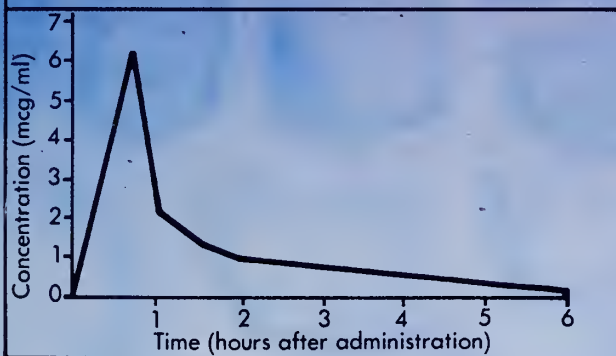
*Dosage should not result in a dose higher than that for adults. †depending on severity

Wyeth Laboratories
Philadelphia, Pa. 19101

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T_{1/2} values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

Wyeth Laboratories • Philadelphia, Pa 19101



NEW
NAME

FOR STRESS PATIENTS

(Chronically Ill, Postoperative, Infection, Inadequate Diet, Alcoholism, Surgery, Burns, Fractures, Febrile Illness, G.I. Disorder, Diabetes, Pregnancy and Lactation)

**ON B.I.D. DOSAGE...
ONLY ONE B-COMPLEX WITH C
PROVIDES A SMOOTH,
CONTINUOUS, PREDICTABLE
RATE OF RELEASE THROUGH
MICRO-DIALYSIS DIFFUSION
24 HOURS A DAY**

B-C-BID Capsules

B COMPLEX WITH C

For stress situations, good nutrition or whenever B-Complex with C is indicated...B-C-Bid is better. Its exclusive delivery system (sustained release through micro-dialysis diffusion) provides a smooth, continuous release of essential vitamins which frees your patients from the "peak and valley" effect of ordinary capsules or tablets...without regurgitation or after-taste.

Your patients deserve the predictability that only B-C-Bid can offer. The clinical results suggest that you prescribe it.

EACH B-C-BID CAPSULE CONTAINS:

Vitamin B-1 (Thiamine Mononitrate)	15mg
Vitamin B-2 (Riboflavin)	10mg
Vitamin B-6 (Pyridoxine)	5mg
Niacinamide	50mg
Calcium Pantothenate	10mg
Vitamin C (Ascorbic Acid)	300mg
Vitamin B-12 (Cyanocobalamin)	5mcg

DOSAGE: For continuous 24 hour therapy, one capsule after breakfast and one after supper.



Samples on request.

GERIATRIC PHARMACEUTICAL CORP.
397 JERICHO TURNPIKE, FLORAL PARK, N.Y. 11001



PIONEERS IN GERIATRIC RESEARCH
DEVELOPERS AND SUPPLIERS OF CEVI-BID • GER-O-FOAM • ISO-BID

AVAILABLE ONLY THROUGH THE MEDICAL PROFESSION



President's Page

Medicine and History

"Those who cannot remember the past are condemned to repeat it."

— George Santayana

Most of us will benefit by realizing that the study of history can help us in many of our current activities. The doctors of Florida are most fortunate to have a dedicated group of friends and colleagues who provide us an opportunity to avoid at least some of the problems of needless repetition of the past through the annual historical issue of *The Journal of the Florida Medical Association*. These special issues have enabled us to learn more about our forebears. An awareness and understanding of their efforts can frequently be translated into an improved understanding of the problems which we face in the field of medicine today.

The beginning of August has come to mean to the readers of *The Journal* that the annual historical issue is on its way. This summertime tradition began in 1965 when Dr. Thad M. Moseley was editor of *The Journal*. At that time, under Dr. Moseley's leadership, a systematic program for recording historical items of interest was established and an issue of *The Journal* was devoted primarily to the publication of such historical items. The orientation of one issue to historical items continued for an additional two years under Dr. Moseley and was so popular that, when Dr. Moseley was succeeded as editor of *The Journal* by Dr. Franz H. Stewart in 1968, it was decided that *The Journal* should have a formal historical issue each August. This tradition has continued to the present under the editorships of Dr. Stewart, Dr. Clyde M. Collins, Dr. Gerold L. Schiebler, and now Dr. Daniel B. Nunn. Dr. William M. Straight, who had made significant contributions to the first three issues of *The Journal* devoted to historical items, was made the official history editor for the expanded 1968 issue, a position which he has continued to fill to the present.

All of the members of the FMA are indebted to Dr. Straight for the outstanding job he has done gathering

important articles on the history of medicine in Florida and publishing them for the interest of all *Journal* readers. This year there are articles on pre-hospital mobile emergency care, the Spanish flu of 1918, and Pensacola's early hospitals. All the articles are informative and well worth the necessary time and effort to read them. They will give readers an important insight into the human aspects of the problems encountered in these three areas of medical history.

The three articles show the wide range of time frames in which the history of medicine may be considered. The article on pre-hospital mobile emergency care documents the fact that this type of emergency care did not actually begin on a systematic and comprehensive basis until the mid-1960s. In the relatively few years since then, this form of emergency care has developed into the highly sophisticated and effective program which is now being taken for granted throughout virtually all of the United States. As recently as 1965, the Emergency Medical Service Committee of the FMA was devoting its energies to a consideration of hospital disaster plans and to a program for establishing mobile emergency hospitals which could be moved to the scene of a major catastrophe. The committee was also fulfilling its responsibility of advising the Selective Service System relative to the calling up of physicians for active military duty. At the present time the committee is deeply involved in considering the problems of the system of pre-hospital mobile emergency care described in the article. An awareness of the development of this new program of emergency care will help us to understand some of the problems inherent in the development of any new system of medical treatment.

The study of the Spanish flu covers a rather short period in 1918 when influenza caused major problems for Florida and the entire nation with literally thousands of

people dying as a result of this highly virulent viral disease. Although this epidemic lasted only a short period of time, the authors point out that recurrent epidemics of this type may be anticipated to recur on a cyclic basis. The annual administration of influenza vaccines to significant numbers of United States citizens holds the promise of breaking up the cycle.

The article on Pensacola's early hospitals provides a graphic portrayal of the development of hospital services in a medium-sized city. From the early days in which hospitals were virtually death houses until the first part of the Twentieth Century when hospitals began to provide the services now readily available everywhere, the article documents a dramatic change in hospital services. Medicine as we know it today could not provide the highly effective quality of care without the physical facilities and services found in hospitals. We need to know more about the beginnings of modern hospitals in order to appreciate

our present institutions.

Through all of these articles the theme of the history of medicine is that of people working together to improve the quality of medical care. Although the scientific progress of medicine is well-documented by reports in the scientific literature, such reports almost never consider the personalities and human factors involved in scientific advances. The three historical articles in this issue go beyond the documentation of scientific achievement and give insight into the human factors involved in the advances of medicine. Individually and collectively the historical issues of *The Journal* will help us to have a better understanding of our medical predecessors and avoid the trap of unnecessarily repeating the past as pointed out by Santayana. Dr. Straight and his colleagues are to be commended for the outstanding job they have done in providing this invaluable service to all readers of *The Journal*.

Sanford A. Mullen, M.D.

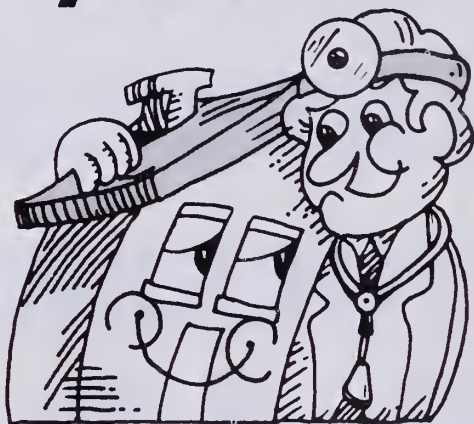
**REINSURANCE
BROKERS for
Florida Physicians
Insurance Reciprocal
—serving physicians
throughout Florida**



**The
Wetzel
Company,
Inc.**

P.O. Box 66452 · Houston, Texas 77006

When you need a lot of money, DAC and your house may be the best friends you have.



As a physician, cash flow and large dollar requirements can sometimes be a problem. Probably one of your biggest assets and surest means of obtaining large cash sums is your home equity.

Let DAC show you how simple it can be to arrange a home equity loan. Loans are available for up to \$50,000 or more with terms up to 12 years.

So, if you need cash for setting up or expanding a practice, new equipment, business investments, major purchases, etc., call your nearest DAC office — there are 13 in Florida!

Licensed Mortgage Broker

DAC
Corp. of Fla.

An affiliate of The Old Stone Bank

Professionals Helping Professionals For Over 20 Years

Bradenton

6221 14th St. West
756-9575

Clearwater

2280 U.S. Highway 19 N.
796-2587

Daytona Beach

2040 S. Ridgewood Ave.
761-8500

Ft. Lauderdale

1771 N. W. 40th Ave.
735-5111

Jacksonville

3986 Boulevard Center Dr.
396-9496

Lakeland

402 S. Kentucky Ave.
687-2533

Melbourne

17 E. Hibiscus Blvd.
727-3510

Ocala

2945 N. E. 3rd St.
732-4336

Orlando

3438 Lawton Rd.
894-3711

Pensacola

5150 Bayou Blvd.
478-3215

Tallahassee

2574 Seagate Dr.
878-3149

Tampa

402 Reo St.
879-3181

West Palm Beach 2240 Palm Beach Lakes Rd. 689-0080

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid over-sedation. Terminate dosage gradually since abrupt withdrawal of any anti-anxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown, but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chloridiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan[®]
for (lorazepam)
Anxiety

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.



Four practical reasons to prescribe **Ativan[®]** for (lorazepam) **Anxiety^{*}**



1

No interaction with more than 300 drugs[†]

In clinical studies, Ativan was given concomitantly with hundreds of medications, including gastrointestinal and cardiovascular, with no reported interactions. Whereas the interaction of diazepam and cimetidine has been shown to cause increased sedation in patients taking both drugs, the clearance of Ativan is not delayed by Tagamet.[‡]



2 Lets most patients stay active

Long-acting benzodiazepines have long-acting metabolites with activity which can produce excessive accumulation that may lead to unwanted sedation. Ativan[®] has no active metabolites, reaches steady state in 2 to 3 days and usually does not cause oversedation. Also, the shorter half-life of Ativan is consistent with b.i.d. dosage, so drug hangover is seldom a problem the next morning.

3

Not appreciably affected by aging

Unlike the long-acting benzodiazepines—diazepam [®], chlordiazepoxide [®], clorazepate [®] and prazepam [®]—the metabolism and clearance of Ativan are not appreciably affected by the aging process.



4

Not significantly affected by liver dysfunction

Ativan[®] is metabolized in one simple step to an inactive glucuronide; its absorption and excretion are not significantly altered by cirrhosis or hepatitis. By contrast, the metabolism of diazepam and chlordiazepoxide has been reported to be significantly altered in patients with liver dysfunction.

^{*}Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic.

[†]All benzodiazepines, however, produce additive effects when given with CNS depressants, such as barbiturates or alcohol.

[‡]Tagamet (cimetidine) is a registered trademark of Smith Kline & French Laboratories, Division of SmithKline Corporation.

Copyright © 1981, Wyeth Laboratories. All rights reserved.

See important information on following page.

Wyeth Laboratories

Philadelphia, PA 19101



TM

EIGHTH ANNUAL REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE

**"FUNDAMENTAL AND CLINICAL
ASPECTS OF INTERNAL MEDICINE"**

**SHERATON
BAL HARBOUR**

August 9 - 22, 1981

**MIAMI BEACH
FLORIDA**

Director: Maxwell McKenzie, M.D.

Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for physicians who are preparing for *certification in internal medicine*. It will provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Twelve printed texts, references and self-assessment questionnaires will be provided to all registrants. Pictorial quizzes, patient management problems, videotape symposia and audiovisual teaching aids will be offered throughout the meeting. Upon request the twelve textbooks and self-assessment questionnaires will be forwarded to each registrant before the course begins. This course will end 23 days prior to the certification examination of the American Board of Internal Medicine, thereby providing time for assimilation.

Week I (August 9-15)

Cardiology
Pulmonary
Electrolytes — Renal
Hypertension — Critical Care
Neurology — Psychiatry — Radiology
Ophthalmology — Pharmacology — Toxicology
Dermatology — Laboratory — Geriatrics

Week II (August 16-22)

Endocrinology — Pathology
Infectious Disease — Immunology — Allergy
Rheumatology
Gastroenterology — Hepatology
Hematology
Genetics — Oncology — Nuclear Medicine

HIGHLIGHTS . . .

- | | |
|--|---|
| • Audio-Visual Aids | • Set of 12 Textbooks |
| • Pictorial Quiz | • Self-Assessment Questionnaires |
| • Self-Assessment Sessions | • Meet the Faculty Sessions |
| • Patient Management Problems | • Video Tape Symposia |
| • 88 Lecture Hours of Credit, Category I | • 65 Self-Instruction Hours of Credit, Category I |

Registration: \$650* Entire Course (August 9-22, 1981)
\$400 Week I (August 9-15)
\$400 Week II (August 16-22)

Enrollment must be limited because of extensive faculty/management interaction.

For registration and information write to:

Jose S. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760, Miami, Florida 33101
Phone: (305) 547-6063

*Includes tuition, set of textbooks, self-assessment questionnaires, use of audiovisual aids, library loan of T.V. tapes, cassette tapes and set of slides.

Here We Go Again

During the most recent session of our Florida legislature we witnessed a public campaign to secure approval for the use of Immunoaugmentative Therapy to treat cancer. The campaign was at least partially successful but that is not the point of this editorial. I was impressed by the campaign techniques, inasmuch as they followed a familiar pattern which I recognized from the past. First came the testimonials, those heart rending tales of people who had been cured, or at least greatly benefited, after having been "given up" by traditional doctors following the failure of orthodox treatment methods. Then came the description of the treatment which is based on a concept so simple that even the laity can understand it and wonder why the scientists won't accept it. Alternatively, as with other miracle treatments in the past, there is a secret discovery involved which its detractors are trying to get their hands on. Finally, there is a conspiracy by organized medicine, cancer organizations, and drug companies in order to protect their very lucrative cancer treatment business.

Shades of the Hoxsey cure, Krebiozen, and Laetrile

to mention but three in my memory. I heard the same techniques used in their promotion. Because of the propensity of mankind to exploit another's desperation, I am sure we are destined to see the cycle ever repeated, a new cancer "cure" being promoted to replace the most recent one that has been finally accepted as worthless, and with the same promotional patterns appearing which pushed that last "cure" into prominence.

So be it. The aspect of all this that distresses me, however, is the fact that when a quack promotes his treatment, he is obviously doing it for his own personal gain and yet he is perceived by society as doing it for the good of mankind. On the other hand, when doctors condemn quackery, they are doing it for the protection of mankind and yet they are perceived by society as being motivated by selfish and financial reasons. What are we doing wrong?

*James K. Conn, M.D.
Assistant Editor
Tallahassee*



CAN HOME HEALTH CARE BE A PRACTICAL, COST-EFFECTIVE ALTERNATIVE FOR YOUR PATIENTS?



THIS NEW AMA PUBLICATION CAN GUIDE YOUR DECISION.

Developed by the American Medical Association, the *Guide* is designed to provide you with comprehensive information on all aspects of home health care and to assist you in determining its appropriateness for your individual patients.

While sophisticated and expensive hospital services are often necessary during the acute phase of illness, continued hospitalization during subsequent periods of disability may be neither necessary nor desirable. Physicians should be increasingly concerned with optimum, more cost-effective methods of providing post-hospital care and services, including the use of home health care.

Order your copy today!

Physician Guide to Home Health Care is the only publication available on this very important component of health care. Use the form below to order your copy now.

Order Dept., OP-077
American Medical Association
P.O. Box 821
Monroe, WI 53566

Please send me _____ copy(ies) of *Physician Guide to Home Health Care*, OP-077. Price: \$1.00 per copy for up to 100 copies. Enclosed is my check, payable to the AMA, for \$_____. Payment must accompany order.

Please Print

Name _____

Address _____

City/State/Zip _____

GIARDIASIS.

NOW THERE IS A BETTER METHOD OF DIAGNOSIS WHEN STOOL EXAMS ARE NEGATIVE.

ENTERO-TEST® A 140cm nylon line coiled inside of a gelatin capsule designed to retrieve duodenal contents without intubation. Easily administered and tolerated. ENTERO-TEST® has the following advantages:

- A viable alternative to intubation
- Well tolerated by all age groups
- Pediatric sizes available
- Useful in the diagnosis of bleeding and a variety of intestinal parasites

Rosenthal and Leibman studied 23 pediatric patients with diarrhea. All had one or more negative stools. Of these, 5 patients had *Giardia lamblia*

which was diagnosed by the simple ENTERO-TEST® procedure. Lopez and co-workers diagnosed Giardiasis in 22 patients with the ENTERO-TEST® compared to 4 patients by stool exams. ENTERO-TEST® has proved to be a useful and effective method for the localization of upper GI bleeding, and the diagnosis of Typhoid carriers, strongyloidiasis and other parasitic diseases.

References:

Rosenthal, P. and Liebman, W.M: Comparative study of stool examinations, duodenal aspiration, and pediatric Entero-Test for giardiasis in children. *J. PEDIAT.* 96: 278 (Feb.) 1980.

Thomas, G. L., et al: Use of the Entero-Test duodenal capsule in the diagnosis of giardiasis. *South Afr. Med. J.* 48: 2219, 1974.

Lopez, M. E., et al: Infeccion duodeno-yeyunal en el niño con desnutricion energetico-proteinica. *Rev. Med. Hosp. Nat. Niños* 13: 53, 1978.

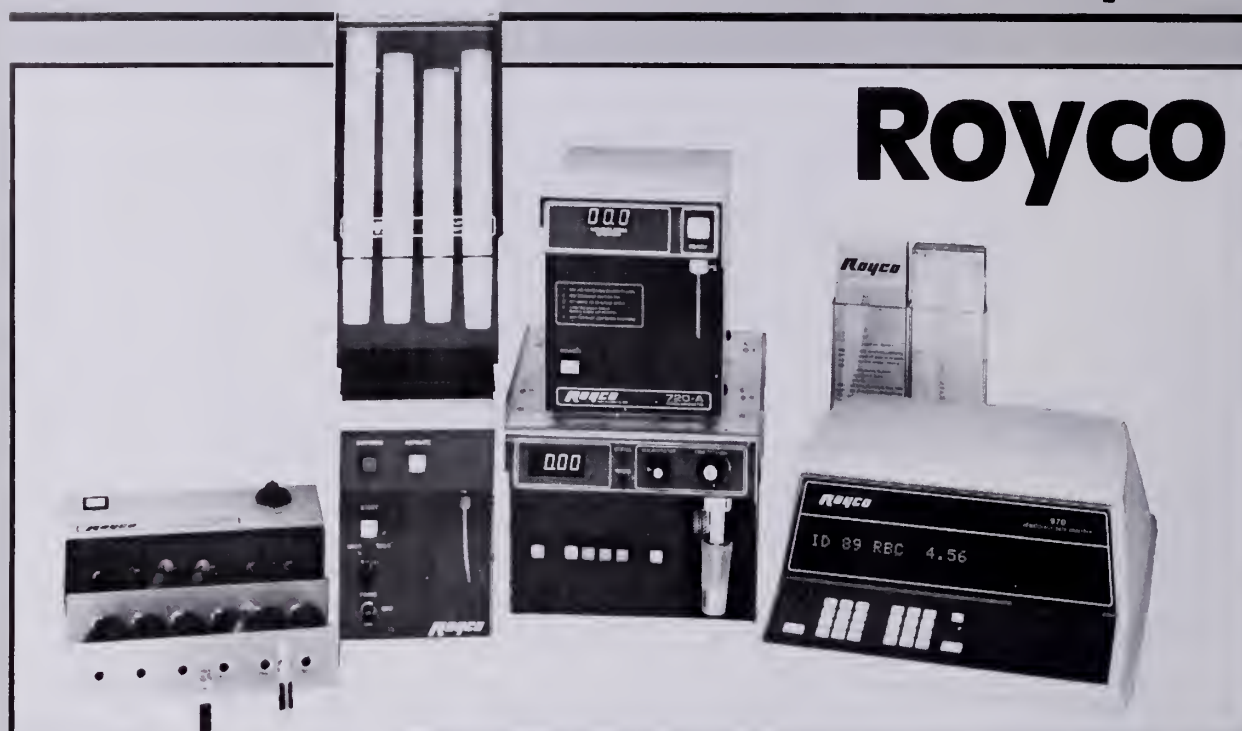
Gilman, R. H: Identification of gall typhoid carriers by a string bladder device. *The Lancet*: April 14, p. 795, 1979.



(800) 227-8162
2351 Casey Ave.

ENTERO-TEST® The Solution Simple And Safe

Save Lab Space



Royco

Doctor, build your own Hematology Lab with a Royco Modular System.

- SPECIAL FEATURES:**
- A 20 ul Sample for Venous or Capillary Testing
 - Quick Platelets (PRP Method)
 - Low Cost Per Test
 - Proven Accuracy
 - Simple Operation
 - Universally Obtainable Reagents

The #921

Platelets, WBC, RBC, HCT, MCV
5 Parameters for .37C

The # 920-A

RBC, WBC, HCT
3 Parameters for .27C

The # 720-A

Hemoglobin
10 Second Testing .7C

The #375

Royco's Dual Ratio Dilutor
Complete CBC on a 20 ul Sample

The #970

Data Analyzer
Printed 7 Parameter Report
with Multiple Quality Control
Program

The # 951

Blood Cell Mixer
Exclusive Dual Action Assures
Complete Cell Re-Suspension

**Start Building
Your System Today.**

Fla. 1-800-432-8940
Ga. 404-968-8256

Royco
CLINICAL DIVISION

A BOEHRINGER MANNHEIM COMPANY
1032 Elwell Court, Palo Alto, CA 94303

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

AUGUST 1981
VOL 68 • NO. 8

Historical Issue

William M. Straight, M.D.
Historical Editor

IN THIS ISSUE . . .

In the past fifteen years the hope of survival for the patient stricken by myocardial infarction, other sudden serious illnesses and accidents has markedly improved. Perhaps the most important single factor in this improved outlook is the development of the prehospital mobile emergency care units throughout our land. Florida has been in the vanguard of this movement. Indeed the first such unit in the United States was developed through the efforts of Dr. Eugene Nagel, Dr. Jim Hirschman and the City of Miami Fire Department. In the first article of this issue Drs. Hirschman and Nagel record the trials, tribulations and successes of their efforts.

The second article of this issue features a return to our pages of the Pensacola medical historian, the wife of

our book review editor, Mrs. Elizabeth Vickers. She brings us an interesting and informative account of the early hospitals in Pensacola.

The final article, written by the historical editor of *The Journal*, details the most devastating of recent epidemics in our state, the Spanish flu of 1918. In the space of little more than six weeks over 4,000 Florida residents died of the flu and attendant pneumonia and many thousands more were severely ill. Business, commerce and the war effort came to a screeching halt.

*William M. Straight, M.D.
Historical Editor*

Prehospital Mobile Emergency Care in Miami, Florida

An Historical Commentary

Jim C. Hirschman, M.D., and Eugene L. Nagel, M.D.

It has been said that there is no real history at all, we have only random maneuverings on which man imposes his own definition and then calls it "history". Others say history, a thin, fragile line, stretches out from an amorphous past, touches us for an instant and then speeds on to a clouded future. For we more ordinary people, history is the story of what happened, what we have experienced and what we put down on paper with some precision so that others may know what happened and find the story useful.

What started in Miami came to be called "Prehospital Mobile Emergency Care". It didn't really begin that way. For Miami it may have begun with a series of plane crashes, one every two or three years during the late 1950's and early 1960's. Numbers of victims were generated each time and the rescue workers repetitively felt the same frustrations in not being able to relieve the grief, the agony and the morbidity. In another sense, it began with a group of City of Miami firemen known as Rescue-1. These aggressive, heroic and dedicated workers were already delivering the best quality emergency service possible for the early 1960's. They overcame their natural distrust of physicians and after a casual introduction in 1964, accepted a physician's offer to work with them in teaching new clinical techniques in emergency care. One man said, "It seemed as if the

doctor just appeared in the evenings at Fire Station 1 teaching advanced first aid and a resuscitation technique called 'closed chest cardiac massage'".

Eugene L. Nagel was that doctor having just arrived at the University of Miami as Assistant Professor in the Department of Anesthesiology. There were only two residents in this department. They quickly soaked up his teachings and left him with considerable, untapped tutorial abilities. Nagel believed in cardiopulmonary resuscitation and was delighted to find a group of fire/rescue men willing to learn. One good omen was that there, in the midst of the equipment carried by Rescue-1, sat a dusty, old doctor's bag filled with outdated medications which was made available to gullible, Good Samaritan doctors who might appear at a rescue scene to help. "They could work with doctors!"¹

Rescue-1 Graduates Move Up

Many of the graduates of Rescue-1 went on to become leaders in the propagation of emergency rescue care. Lawrence L. Kenny went on to become Fire Chief of the City of Miami in 1963. Donald Hickman followed him becoming Fire Chief when Kenny retired in 1974. Capt. Manuel Padron, to whom this article is dedicated, became the first firefighter to devote his entire career to emergency rescue care. He died in April 1973, after 32 years in fire rescue.

Milton Bullock, an early graduate of Rescue-1 went on to become Director of the Fire Department of Metropolitan Dade County. While Ken McCullough went on to become Chief of the Rescue Division and Fire Marshal, Randy Boaz became the most active instructor and educator in emergency rescue science in the region. The list is longer. In all, 30 brave, gutsy firefighters volunteered to take the training and the risks attendant to the innovations imposed by the doctors in the new science of mobile emergency care in the mid-1960's.

The Authors

JIM C. HIRSCHMAN, M.D.

Dr. Hirschman is a cardiologist practicing in Miami, and is a past-president of the Heart Association of Greater Miami, and founding president of the South Florida Emergency Medical Services Coordinating Council.

EUGENE L. NAGEL, M.D.

Dr. Nagel was formerly Associate Professor of Anesthesiology at the University of Miami School of Medicine, and is currently practicing in Winter Haven.

The firemen had a rather universal concern, which was a fear of criticism by the physician community. The concept of paramedics doing things usually reserved for doctors was quite foreign to civilian rescue work. As Chief Kenny described it, "We had to play it very carefully! There was always the risk of criticism!"

It took nearly five years to overcome the anxiety. It took constant reminders that no one expected the paramedics to practice medicine. They were expected to function in a way, precisely defined, as the eyes, ears and hands of the practicing physician on the other end of the radio. Once they experienced the system, to function as an intelligent link in a modern emergency care system, they gained confidence.

Radio Transmission of EKGs

The first radio transmissions of an electrocardiogram across the city began in late 1966 and were made possible by a small orange box called a modulator. It was made by Biocom, Inc. of Culver City, Calif. It took the direct current voltage of a victim's ECG, converted it to an audio tone which could then be carried by radio to the receiving site, demodulated it and wrote it out on ECG paper. These telemetry transmissions were practiced nearly a year before the technique was made public. Using such a Biocom Modulator, "Miss National Fire Prevention" had her ECG signal sent by the paramedics from Miami to Culver City, California in late 1967. This and several other similar stunts were performed to demonstrate the benefit and the reliability of the ECG telemetry.

No one kept a journal but the November 1967 issue of "Fire Engineering" records that the "Miami, Florida, Fire Department officials believe that they are the first in the nation to operate routinely a portable radio device which records the heart action of the stricken patient at the scene and transmits it to a hospital."² This first major step in equipping prehospital rescue units was facilitated by a \$3,000 grant from the Florida Heart Association and a companion grant of \$1,000 from the United Fund of Dade County.

In Florida and around the nation, in a few special centers, some of these same stirrings were taking place. They tended to follow a pattern similar to the Miami system. In late 1967, the 12-13 mortuaries operating ambulance services in Jacksonville, Fla. approached the city government (through a lawyer spokesman) and requested that the city pay a subsidy for their services in addition to the amount charged to the patient/clients. The mayor balked, particularly since the city would have no input into the operation of these private concerns. On November 9, 1967, the matter was resolved when the mayor authorized the city fire department to become the



Fig. 1. — Milk crate transmitter to battery powered E.C.G. receiver. The first test of telemetry, Hirschman, Nagel and Louis Johnson — 1967.

purveyor of rescue services. The transition took 55 minutes from the time the department was notified to the transporting of the first patient.

Fire Department Chief James A. Dowling, who had been advocating this advance for a decade, became Chief of Rescue. He was assisted in the endeavor by Rescue Supervisor Jay Crawford. With the supporting advice of over 25 Duval County physicians, Chief Dowling initiated special training of rescue personnel. CPR, advanced first-aid and extrication training were established and vehicles were redesigned for better interior usage.

In October 1968, Jacksonville's city government was consolidated with the government of Duval County, and Captain John Waters was appointed Director of Public Safety. Together with a committee from the Duval County Medical Society, chaired by Roy Baker, M.D., Captain Waters built on the training initiated by Chief Dowling, implementing advanced rescue courses which included upgraded training by physicians and instruction in reading monitor strips and administering IV's.²³

In the South Trail Fire District near Sarasota, Fla., Chief Jim Sorenson established a special tax district to support his efforts and establish radio connections

between his rescue units and the Sarasota Hospital. Administrative Operations Chief Boone established radio connections between Tampa General Hospital and his city fire department rescue vehicles.

Radio Linkage with S. S. Hope

In mid-1966, Jim Hirschman, M.D. the senior author, a practicing cardiologist in Miami, initiated radio communication with the hospital ship *S.S. Hope* in West Africa providing consultations and promoting the use of overseas radiotelemetry of electrocardiogram using amateur radio frequencies.⁴ The operation was primarily to demonstrate that amateur frequencies and low priced data modulators could be used to accomplish ECG telemetry during emergencies using standard radio communications equipment.

A combining of efforts was natural, with Nagel contributing organizational acumen and a reflex interest in critical care. Hirschman contributed experience in acute cardiology, an internist's methodology to patient assessment and a working relationship with the Heart Association and county medical society.

With a goal of implementing advanced life support for all types of emergencies, an advanced training program for 22 City of Miami rescue personnel was initiated in November 1968. The curriculum included anatomy, physiology, cardiology, gross pathology, endotracheal intubation, patient assessment, radio communication, etc. In all, 22 hours of classroom teaching followed by 54 additional hours of hospital and laboratory experience took place by June 1969. Interventions beyond simple hemostasis and splinting had not yet been practiced in the city streets of the United States, and assurance had to be given to the Fire Chief and the City Manager that no victim's life would be risked or therapeutic misadventures threatened by any of the proposed new techniques.

The first step was merely to teach better first aid and a knowledgeable approach to patient assessment. The second step was to teach the men to recognize life threatening rhythm disturbances. A natural outcome of these observations lead to the discovery that about one-half of the patients being pronounced dead in the emergency rooms, at the time, had some electrical activity of the heart compatible with viability!⁵

Patients With Viable Rhythms

It was evident that these patients with viable rhythms should receive the benefits of resuscitation. Practice in the dog lab with an external electronic defibrillator was intensified. With tongue in cheek, Nagel told Chief Kenny, "We are merely planning to put back into the victims some of those electrical currents we took out during ECG telemetry."

The first successful defibrillation of a patient in the streets of Miami occurred in June 1969, the patient being Dan J., a skid row derelict. His life was changed by the event. He responded to the follow-up interest we showed him by cleaning up, stopping drinking and wearing clean clothes. The resuscitation had not only salvaged his heart but also salvaged his self-image.

During the remainder of 1969, defibrillation by rescue was not common. It was a period of training and the communications system was incomplete. One patient was defibrillated who lived seven days, another 18 months and a third over three years. By August 1971, defibrillation had been attempted on 89 patients. There were 25 who lived one to 30 days, and 16 became long-term survivors with normal central nervous system function. The salvage rate was over 17%, equal or better than in most hospital wards!

Between April 1970, and July 1973, the paramedics had attempted defibrillation on 310 patients. The abnormal rhythm had been successfully terminated in 200 of these cases (65%). Of these, 120 patients were pronounced dead in the Emergency Room and 80 (26%) survived to be admitted to the wards. Half of these, or 40 (13%), became long-term survivors. The hospital course of the survivors showed that one-third of them had suffered acute myocardial infarction, one-third had suffered acute coronary ischemia without infarction and the remaining one-third had suffered only ventricular fibrillation without evidence of acute ischemia or infarction. It was clear then that hearts with advanced coronary artery disease could suffer acute, fatal rhythm disturbances without acute pathologic changes, in a significant fraction of the studied group.¹¹

Table I

City of Miami Fire Department—Rescue Division IV Starts By Major Case Categories

July 27, 1970 — June 30, 1971

SURGICAL:

Trauma—auto	30	
Trauma—gunshot	57	
Trauma—other	52	139

MEDICAL:

Heart-related	170	
General Medical	16	
Unconscious and		
Drug Overdose	36	222

MISCELLANEOUS:

TOTAL	406
-------	-----

Table II
City of Miami Fire Department—Rescue Division
Major Categories of Emergency
Medical Service Runs
1961 and 1970

	1970	1961
TOTAL EMS RUNS	6,367	380
AUTO ACCIDENTS	1,370	116
Head Injuries	739	42
Fractures	326	78
"HEART ATTACKS"	1,380	64
EMS RUNS AS PERCENT OF ALL FIRE DEPT. RESCUE DIVISION RUNS	67%	30%

Mobile Coronary Care Or Mobile Emergency Care?

The first established mobile prehospital coronary care system appeared in Belfast, Northern Ireland, under the direction of Pantridge, Geddes and Scott.⁶ It was employed exclusively for patients with acute myocardial infarction. Their success in salvage was real. Michael Scott reported in 1969⁷ the tally showed "the first 39 patients who were successfully resuscitated outside the hospital". Access to their system occurred when a family doctor determined that a person was suffering acute myocardial infarction and then the "flying squad" was dispatched from the Royal Victoria Hospital to the victim's side. What emergency care was provided for victims of other human emergencies in Belfast is not reported. The Pantridge group was aware that its system had a built-in delay to access and that there was great necessity for a rapid response to the victim's need. In their words, "We in Belfast are impressed by the fact that

unless ventricular fibrillation can be diagnosed and treated very rapidly, without the need for transportation to the hospital, the prognosis is very poor!"

Other early systems were established by Grace in New York City⁸ and Warren in Columbus, Ohio⁹. These, too, were oriented toward the management of the acute coronary emergency. As in Belfast, the vehicles were staffed with physicians, nurses and medical students.

The mobile emergency care systems emerging in 1969-1971 in Miami, Los Angeles, Seattle and Jacksonville were built around fire departments and fire departments were responding to *all* types of human emergencies not just myocardial infarction. In Miami in 1970, emergencies due to auto accidents were just as common as emergencies due to "heart attacks". In addition to trauma and heart attacks the paramedics were encountering emergencies with asthma, poisonings, drug and diabetic coma, insulin reactions, seizures, etc. All of these could benefit from prehospital intervention. This meant that the paramedics should be trained and equipped with more than just ECG telemetry and defibrillators. To follow through with advanced resuscitation and treatment techniques for all types of emergencies they needed to be taught to start intravenous fluids. They needed to learn to administer appropriate medications. Table I shows the number of IV starts through June 30, 1971. Table II shows the types of emergencies encountered in a typical year of rescue operation. Table III shows the types of drugs administered and the frequency of their use during the first six months. Morphine was used only for acute myocardial infarction and acute pulmonary edema. It was rarely used for simple, uncomplicated trauma.

Although the mobile coronary care units were convincingly successful they were expensive. Their response times were slow. Their staffing was expensive. Within a few years they slowly and smoothly gave way to mobile emergency care systems with a breadth of

Table III
City of Miami Fire Department—Rescue Division
Drugs Administered On Radio Command
December 27, 1970-June 30, 1971

DRUG	DOSE	NUMBER OF CASES*
Sodium Bicarbonate	44mg	32
Atropine	1mg	15
Epinephrine	1mg	14
Lidocaine	100mg	7
Calcium Chloride	1gm	1
Morphine	15mg	14
Diazepam	10mg	5

*Note: In a few instances multiple drugs were administered.



Fig. 2. — Capt. Padron displays radiotelemetry field unit in aluminum suitcase, 1970.

capabilities to deal with all types of human emergencies.

Federal Grant Funding Encouraged System Development

Once the basic concepts and the initial radiotelemetry hardware had been tested there was the need to expand the rescue activities throughout the city of Miami. This expansion took place under a National Highway Traffic Safety Administration grant, UM-NHTSA-FH-11-7198. It started in June 1969, and ran for two years. Under this grant the major components of Miami's modern mobile emergency care system were developed. The appropriate type of vehicle was determined. The benefits of senior supervision were discovered. The necessity for community involvement was made obvious. Hirschman established the Acute Cardiac Care Committee of the Heart Association and wrote a curriculum for public education (CPR — Citizen's Plan for Rescue).

Some of the conclusions listed in the final report from the NHTSA study are worth repeating: "Every day in the United States enormous numbers of highway and other injuries and acute illnesses need medical care (prehospital). A large percentage of these require care on an emergency basis even before transport to the hospital — indeed, in order to survive that transport! These emergencies are sudden, unexpected and panic laden situations. Management of them is best intrusted to people who are strategically located, who are always available and whose sole function is to respond to an emergency alarm. Most physicians do not meet this job description. A staff of specially trained, career experienced rescue workers is bound to be better at the job than physicians whose experience with emergency medicine is often limited. The work requires frequently the vigor of youth and the use of heavy equipment not regularly employed, even by the best intentioned doctor on the scene."

The report continues in 1971, "Present stage of development of communication arts is sufficient to enable almost any area to deliver good quality advanced emergency care to the injured and acutely ill. Higher caliber paramedics can be attracted by offering better training, more pay and status recognition. Care and assignment of paramedics is needed to insure good rapport and acceptance by the community. Language barriers should be avoided."

More Qualified Physicians

The report also highlights the need to enlist more qualified physicians in various stages of emergency medical services, the need for refresher courses for paramedics, a national program for training and registering paramedics to uniform high standards and the

establishment of regional agencies to determine criteria and standards and disseminate information and advice (coordinating councils). That 1971 report by the authors also encouraged the search for clear radio channels to be made available for local rescue use, cooperation between the many levels of government and public agencies and a central data bank to collect data from presently fragmented sources.

The other major grant was obtained from the National Heart and Lung Institute, NIH-NHLI-70-2072 and the effort was directed primarily to the study of sudden and unexpected cardiac death in the prehospital phase. At that time Sidney Nussenfeld, J.D., Joseph Davis, M.D. and Richard Liberthsen, M.D. were added to the research staff. Similar contracts ran concurrently in San Francisco (Meyer Friedman), Baltimore, Md., (Louis Kuller), Columbus, Ohio (Nobuhisa Baba) and Atlanta, Ga. (Nanette Wenger). Some of the outcome data is mentioned above. Contributions to the literature coming from the project dealt with the pathology and physiology of sudden and unexpected death as well as with techniques and equipment used in resuscitation.^{10,11,12,13,19}

Senior Supervision

A special feature was part of the Miami system from the beginning. This was the employment of two-way handie talkie radios by the supervising physicians. These radios, now rather commonplace, were about the size of a narrow brick. They hung on the physician's belt, were powered by rechargeable batteries and allowed communication from any convenient spot within the county to the rescue workers at the scene of their activity. The handie talkie provided the authors with the opportunity for supervision without the need to be confined to a hospital or any single transmitting site. The supervising doctors now had freedom to move through the community and, when needed, could respond to a rescue scene while continuing radio contact. Senior radio supervision with handie talkies permitted monitoring of quality of care being delivered by the hospital based physicians as well as that of the rescue workers in the field. Corrective transmissions could be made when required.¹³

Mobile emergency care is the practice of medicine in a very specialized way. It is much more than advanced first aid. Moment to moment decisions profoundly affect morbidity and mortality. For that reason a qualified physician must be immediately available for radio consultation. Not all physicians have the temperament for this work. They must be cognizant of major community care resources, have a full understanding of the training and equipment carried by the paramedics and must be able to visualize a patient sometimes never seen in person.¹⁵

Mobile-Mobile Repeaters Established as Essential

One requirement for handie talkie communication was that of centrally located mobile repeater transmitters. The Miami system evolved around such a mobile repeater but was operating under an experimental license. By July 1972, when Hirschman was establishing the emergency care system in Coral Gables, he was unable to get permission to use mobile repeater transmitters. The FCC license offered carried the statement: "Mobile relay operation is not permitted in this special emergency radio service." It was only after a trip to Washington and influence from Senator Lawton Chiles that a waiver was obtained, "on a developmental basis, to enable Coral Gables to test the concept in an operational environment and provide the FCC with information necessary to determine whether its rule should be amended to permit mobile relay . . ." That breakthrough and the documented comments of Nagel to FCC docket 19-261 established that radio frequencies in the emergency medical services ultimately would include mobile-to-mobile relay. The difficulty had come because the Commission envisioned telemetry as a continuous activity rather than short bursts of ECG information supported by voice communication.

Vehicular Type and Transport Policies

From the earliest development of the Miami system problems arose regarding management attitudes and policies. One of these was the capabilities of the rescue vehicle. For 20 years and more fire department rescue trucks carried heavy equipment, levers, chains and pulleys, crowbars and smoke fans. With the advent of modern skills the old trucks were too slow and the new equipment was not as heavy. Smaller vehicles were sought. Additionally, there was the need to have the option to transport a gravely ill victim when necessary. Dependence on a third service, the ambulance system, had to be circumvented in certain dire emergencies. The ideal vehicle would be light, well equipped, and capable of patient transportation when necessary.

No such vehicle was immediately available and so it was created. The first one is shown on the cover of this issue of *The Journal*. It was a stock recreational van but with the top raised to allow standing room. Cabinets were tailor-made for the equipment needs of the rescue team. It was first put on the streets in late 1969 and was rapidly copied by a number of private manufacturers. Current versions of these vehicles have the same capabilities although they have grown a bit in size.

As the years have passed the volume of fire department dispatches related to emergency medical care has risen and now constitutes nearly 60% of fire department runs in most urban areas. This has raised the question of whether a third service, not the fire



Fig. 3. — Capt. John Waters, Jacksonville, displays later style rescue vehicle, 1974.

department, but strictly dedicated to human emergencies should be created. A third service requires a major capital investment. It would respond to only human emergencies and not to physical disasters such as electrical catastrophies, chemical spills, building collapses, bridge collapses and other similar catastrophies except when accompanied by fire department rescue workers who are trained to handle these situations. The double dispatch would be an unnecessary redundancy when cities like Miami, Jacksonville, Tampa, Seattle, Wash.; Los Angeles County, Calif., had all demonstrated that the fire department could do the job very well.

Another Policy Decision

Another policy decision centered around whether physicians should ride regularly with the rescue team. As has been mentioned, the mobile coronary care systems in Belfast, Columbus and New York City did carry physicians, but they were disease oriented. Because of limited budgets and growing success of career paramedics, most prehospital care systems utilized physicians only as radio consultants often with one doctor for three to five rescue teams. In the City of Miami Beach, where rescue care was implemented in 1971, one citizen proposed a referendum that "Licensed physicians should be hired by the city to ride in the mobile care vehicles." It passed and failed to be repealed. It remains that way today in contrast to every other system in the country. Others have concluded that capable emergency care physicians cannot be hired in adequate numbers and on limited budgets to staff all the rescue vehicles, and that the quality of care delivered by prehospital teams staffed by paramedics remains extremely high due to dedication, career orientation and medical supervision.

Equipment Innovation

The rapid growth and success of emergency care in Florida provided opportunities for the testing of new and

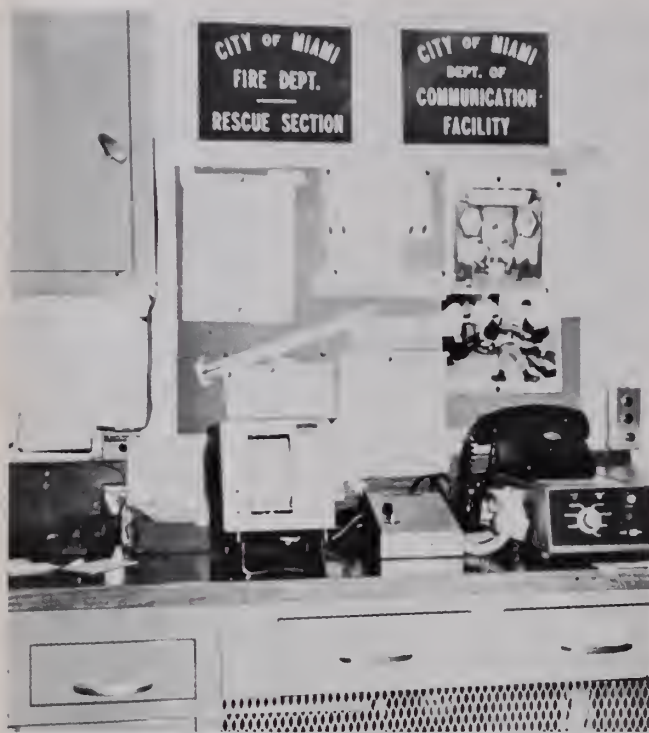


Fig. 4a. — The first base station console, Jackson Memorial Hospital, 1968.

somewhat untried equipment. The whole series of “Life-Pak” defibrillators was field tested in Miami. Manufacturers soon learned that life in the streets is a rugged test for man and equipment and adapted their gear appropriately.

Michigan Instruments requested field testing of the mechanical chest compressor. It was gladly welcomed by the Miami paramedics. It worked well, never got tired, performed chest compression even on vertical victims and freed another paramedic to run the radio or further accomplish resuscitation.

In early 1972, the authors were invited to consult in Israel by the Magen David Adom (Red Cross in Israel). In that country all ambulance and emergency care is delivered by the MDA. In April of that year the details of the Miami system were presented in Tel Aviv, Jerusalem, Galilee and Cesarea-Kfar Sava. Concepts of staffing were discussed, plans were made to write a curriculum in Hebrew, and demonstrations were given in ECG telemetry. This work continued when Dr. Nancy Caroline was introduced to the Israelies by Nagel.

Then in late 1972 a military surgeon, Burton Kaplan, contacted one of the authors (Nagel) and asked that the military antishock trouser be tested in the Miami civilian population. The results were impressive. Hemorrhagic shock, especially when due to bleeding below the diaphragm, responded dramatically to the application of these inflatable G-suits. It was like transfusing two units



Fig. 4b. — A modern fire/rescue radio console, Doctor's Hospital, Coral Gables, 1974.

of blood into the victim in less than 80 seconds. Often the pressures stayed up until the patient was taken to surgery or until an unwitting emergency room person cut off the trousers not realizing what they were.¹⁹

Enabling Legislation and Definition of Prehospital Care

With the rapid increase in the capabilities of the paramedics and the complexity of human emergencies they were encountering through 1969 and 1970, the authors recognized that they were getting out on a legal limb, delivering medical care under a new system. While the paramedics were not practicing medicine they were assisting the radio doctor in the delivery of medical care and there were no laws to cover this.

The first state law was the Wedworth-Townsend Act in California, April 1970. It permitted any hospital, “operated by or contracting with a county with a population of over 6 million to conduct a pilot program utilizing mobile intensive care paramedics for the delivery of emergency medical care to the sick and injured.” This effectively limited California emergency rescue systems as we now understand them to function only in Los Angeles County.

In spite of this weakness a number of items were defined for the first time. The law said, “Mobile intensive care paramedics means personnel who have been specially trained in emergency care and noncardiac care in a training program certified . . .” It provided that the paramedics as well as mobile intensive care nurses could, under the law, do the following: “Render rescue, first aid and resuscitation services. Do this at the hospital while caring for patients in the hospital, administer parenteral medications under direct supervision of a physician or a registered nurse. Perform cardiopulmonary resuscitation and defibrillation in a pulseless, nonbreathing patient . . . (and where) voice contact or telemetered ECG is monitored and treatment authorized may upon order of

such physician or such nurse do . . . administer intravenous saline or glucose, perform gastric suction, administer parenteral injections including antiarrhythmic agents, vagolytic agents, analgesic agents, alkalinizing agents and vasopressor agents."

1972 Florida Law

The authors pushed for a similar law for Florida and to our knowledge the Florida law was probably the first to facilitate prehospital emergency care on a statewide basis. It was passed in March 1972, with the help of Sens. George Hollahan and Kenneth Myers; the law gave permission to provide emergency medical care by paramedics under a physician's supervision. The wording was more general than the California law, providing that the paramedics could "perform all reasonable activities required to accomplish resuscitation." The first Florida law then was refined into more sophisticated wording and signed into law under the Florida Emergency Medical Services Act of 1973 in June of that year. The legislature also appropriated \$604,000 to be used to help administer the provisions of the act and provide grants-in-aid to counties and cities to help them upgrade emergency medical care.

All the mobile emergency care systems enjoyed enthusiastic community acceptance once they demonstrated their capabilities and fast response, the alleviation of suffering in a professional way and the reduction of mortality in numerous specific instances. A small minority raised questions about the threat of negligence and malpractice lawsuits. Fortunately, the close medical supervision of the paramedics, the depth of their training and their dedication to relieve suffering in a professional way have all worked together to keep lawsuits almost to a zero level. On those rare occasions in Miami where victims' families or friends threatened lawsuits both they and their lawyers withdrew the complaints when it was explained to them what really had gone on at the rescue scene. Documentation of vital signs, radio conversations and telemetry rhythms remain the recommended cornerstones of defense in these matters. Most times these questions arise when the victim is already dead but the family cannot perceive that the heart attack or trauma have been that severe. They become convinced that the rescue workers caused the death, because it happened so fast. Undoubtedly, lawsuits will be filed from time to time despite the best of training, equipment, and the highest of motives on the part of the emergency care team.

The Crash of Flight 401

By the winter of 1973 the 35 square miles of the City of Miami were fully served by the maturing prehospital



Fig. 5. — Typical application of advanced life support skills, streets of Miami, 1971.

mobile emergency care system. About midnight the last weekend in December a call came that a Lockheed 1011 Tristar Jet had crashed in the Everglades. Within 15 minutes of notification the authors along with four paramedics sped to Opa Locka Air Field where we were put on a Coast Guard helicopter and taken with our assembled equipment to the crash scene. There was little time for discussion. The helicopter noise drowned our speech. We were willing and experienced in street emergencies but the crash scene held some surprises.

The night was pitch dark. Only by involving one hand with a flashlight could one see to work or move about. Standard medical skills took a backseat to swimming and wading through water, 2 to 6 feet deep. Someone asked us to set up a gasoline generator powered light but could it be floated on? The Coast Guard and Air Force Helicopters had already begun evacuation of victims. The plane was in 10,000 pieces. Where were the remaining living victims in all that mess? Intuition told us that the ones not calling out were the most severely injured. There was no usual radio communication. We were too far from our base stations for that. Besides our belt radios were dragging in the water.

Within 40 minutes at the crash scene we had triaged the 30 remaining victims. Only two I.V. fluid sets were started. The other patients were simply placed on stiff boards, splinted and evacuated. Morphine was avoided to prevent loss of sensorium or airway in these unaccompanied patients.

We learned a valuable lesson. Disaster work requires preparation different from single patient fire rescue response. Some of the skills are transferable but disasters stretch the day to day rescue systems beyond standard limits in terrain, communications, transportation and medical priorities.



Fig. 6. — There must be a limit!

Coordinated Community Effort

In Miami, Jacksonville, Tampa and Sarasota, the developing emergency care systems were all founded on existing community resources. These included the fire department, both academic and non-academic physicians and public officials at the city, county and state levels. It required the support of medical societies, heart associations and community service groups. The authors believed all along that emergency rescue care is a service which should be provided to a community just like police protection and fire suppression.

The acceptance of the Miami system was expedited by active support of these groups as well as specific support such as the Miami Dolphin's football team. They provided money for fully equipped propane powered Cushman tricycles to offer emergency care in the Orange Bowl, a spinoff of the Miami system.

Coordination within the medical field can bring economy as well as quality assurance. There are eight major clinical areas which must be recognized if care is to be adequate. These are: the cardiac emergency, the polytrauma emergency, major burns, spinal cord injuries, poisonings, metabolic emergencies and drownings, behavioral emergencies, and childbirth or neonatal emergencies. Experience has shown that the community, to be fully prepared, must consider each of these clinical areas in training, equipping and planning for fixed facility resources.

Not every hospital needs to be the ultimate referral

center for each of the clinical areas. A number of hospitals no longer maintain obstetrical units. Only a few hospitals maintain in-house psychiatric units. Only the major medical centers in Florida undertake to provide burn treatment centers and spinal cord centers.

Emergency Care Networks

As Floridians move to establish emergency care networks or trauma networks, each community must plan on a regional basis which hospitals are interested and prepared to accept patients in these clinical areas. Every hospital has a specific role to play. The statement to the public by each hospital should be "If you have a dire emergency (eg., trauma) you have a better chance for survival because this hospital participates in the regional emergency care program". When this relates to trauma the statement is "This hospital is not necessarily a trauma center but your chances for survival are better because this hospital cooperates in the regional trauma network."

Historically in emergency mobile care, the cardiac emergency was dealt with first because it was evident that patients were dying in ventricular fibrillation and could respond to appropriate interventions, CPR and defibrillation. It was easy to measure life and death situations. Now, 10 years later, interest has shifted to the victims of polytrauma, and data has shown rather convincingly that an aggressive approach, here too, reduces mortality and morbidity.^{17, 18} At the time of this writing three regions in Florida have gone through a cycle of federal funding in an effort to establish a community wide plan for trauma care. These are the Florida panhandle, the greater Orlando area and the Dade/Monroe area (South Florida Emergency Medical Services Coordinating Council). The impact in Florida regarding trauma care has not been profound. The effort is still in the formative stages and those involved should be encouraged to continue planning better ways for each region to care for the trauma victim.

Summary

There are many definitions of history but for the most of us history is the story of "what happened", put down in a way so that the reader may use the

Table IV
E.C.G. Telemetry, Miami Fire/Rescue
33 Months — Rhythms Obtained

Normal Sinus Rhythm	700
Tachycardias (all types)	700
Bradycardias (all types)	80
Ventricular Fibrillation	340
Idioventricular Rhythms	50
Asystole	100



Fig. 7. — Senior supervision of fire/rescue by means of handie talkie.

documentation for planning future efforts. In Miami it began when a number of factors worked in concert. The motivation and the potential was already present in Rescue-1, City of Miami Fire Department. Nagel offered enthusiasm for resuscitative techniques and a sway for organization. Hirschman offered interest in quality bedside care and a working knowledge of radio communications. Together a curriculum was developed to train the fire/rescue personnel in advanced life support. ECG telemetry was implemented to verify critical cardiac rhythm disturbances. This telemetry promoted confidence at both ends of the rescue communication. Fire Chief Lawrence Kenny bit his lip, suppressed his anxiety, listened to the doctors and let them plant their new techniques in the streets of his city.

Equipment and concepts had to be developed rapidly. Almost concomitantly there had to be developed the design of a proper vehicle, the arranging for legislative permission for this new venture in clinical care and the development of a concept of community effort not monopolized by any one institution. It included the application of a mechanical chest compressor, of military antishock trousers and faster ways to verify rhythm disturbances.

Through history many significant inventions occurred in several places throughout the world almost simultaneously. Such is the case for prehospital mobile emergency care. The implementation of these modern concepts took place almost in the same year in Miami, Seattle, Los Angeles County and Montgomery County, Md. Within two years similar systems were started in Jacksonville, Tampa, Ann Arbor, Mich., and Charlottesville, Va. Those in Florida and especially those in Miami are proud to say that they were some of the first.

Dedication

This paper is dedicated to the memory of Capt. Manuel Padron of the City of Miami Fire Department, whose efforts gave impact to the development of the system.

References

1. Moore, O.J., and Nagel, E.L. Medics and Fire Fighters Join to Provide Disaster Medical Team. *Fire Engineering* 119 (6): pp. 48-49, 1966.
2. Kenny, L., Nagel, E. L. and Demby, B. Cardiograph Radio Transceiver Pioneered for Use in Vehicles by Miami Fire Department, *Fire Engineering* Vol. 120 (11), Nov. 1967, p. 48, November 1967.
3. Baker, R.M., and Waters, J.M. Use of General Duty Ambulances and Mobile Coronary Care Units, *Journal of the Florida Medical Association* 57 (11), pp. 22-23, November 1970.
4. Hirschman, J.C., Baker, T.J., and Schiff, A.F. Transoceanic Radio Transmission of Electrocardiogram, *Diseases of Chest* 52 (2), pp. 186-190, August 1967.
5. Hirschman, J.C., and Nagel, E.L. Telemetry of ECG by Fire/Rescue Team, An Evaluation, *Circulation* 37, 38 (Suppl. VI), p. 45, October 1968.
6. Pantridge, J.F. and Geddes, J.S. A Mobile Intensive Care Unit in the Management of Myocardial Infarction, *Lancet*, 27, pp. 271-273, August 1967.
7. Scott, M.E., Personal Communication, April 22, 1969.
8. Grace, W.J. and Chadbourne, J.A. The Mobile Coronary Care Units. *Diseases of Chest* 55 (6), p. 452, 1969.
9. Warren, J.V. Mobile Coronary Care in the Logistics of Surviving a Heart Attack, *Medical Opinion and Review* 6 (11), p. 14, November 1970.
10. Liberthson, R.R., Nagel, E.L., and Hirschman, J.C., et al. Pathophysiological Observations in Pre-Hospital Ventricular Fibrillation and Sudden Cardiac Death, *Circulation* 49, pp. 790-798, 1974.
11. Liberthson, R.R., Nagel, E.L., Hirschman, J.C., and Nussenfeld, S.R. Pre-Hospital Ventricular Defibrillation, Prognosis and Follow-up Course, *New England Journal of Medicine* 291, pp. 317-321, 1974.
12. Nagel, E.L., Liberthson, R.R., Hirschman, J.C., and Nussenfeld, S.R. Emergency Care — Sudden Coronary Death Outside the Hospital, *American Heart Monograph* No. 47, pp. 111-216, Dallas, Texas, 1975.
13. Hirschman, J.C., Nussenfeld, S.R., and Nagel, E.L. Mobile Physician Command—a New Dimension in Civilian Telemetry—Rescue Systems, *J.A.M.A.* 230 (2), pp. 255-258, October 14, 1974.
14. The Florida Emergency Medical Services Act of 1973, Florida Statutes, Chapter 73-126, Effective October 1, 1973.
15. Hirschman, J.C., and Findeiss J.C. The Role of the Physician in Mobile Emergency Care Systems, *Journal of American College of Emergency Physicians*, May/June 1974.
16. National Academy of Sciences, National Research Council; Accidental Death and Disability. The Neglected Disease of Modern Society, Washington, D.C., September 1966.
17. Waters, J.M., and Wells, C.H. The Efforts of a Modern Emergency Care System in Reducing Automobile Crash Deaths. *Journal of Trauma* 13, pp. 645-647, 1971.

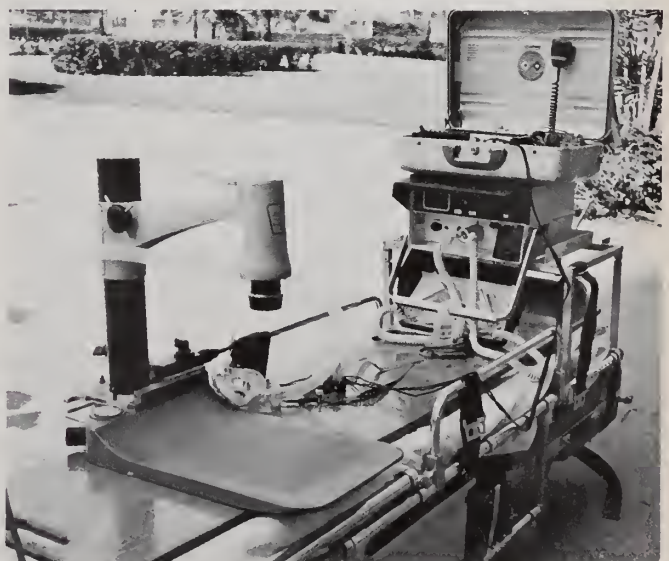


Fig. 8. — Life support stretcher with radio, defibrillator, backboard, oxygen supply and chest compressor.

18. Boyd, D.R. Trauma — A Controllable Disease in the 1980's, *Journal of Trauma* 20 (1), pp. 14-24, 1980.
19. Kaplan, B.C., Civetta, J.M., Nagel, E.L., Nussenfeld, S.R., and Hirschman, J.C. The Military Antishock Trouser in Civilian Pre-Hospital Emergency Care. *Journal of Trauma*. 13:10, 843-848, 1973.
20. Lewis, A.J., Ailshie, G., and Criley, J.M. Pre-Hospital Cardiac Care in a Paramedic Mobile Intensive Care Unit. *California Medic*, 117, pp. 1-8, 1972.
21. Cobb, L.A., Conn, R.D., and Sampson, W.E. Pre-Hospital Coronary Care: The Role of a Rapid Response Mobile Intensive Coronary Care System, Abstracted Circulation 44, (Suppl. II), p. 45, 1971.
22. Lambrew, C.T., Schuchman, W.L., and Cannon, T.H. Emergency Medical Transportation System, Use of ECG Telemetry, *Chest* 63, 47, 482, 1973.
23. Personal communication with Daniel B. Nunn, M.D.

• Dr. Hirschman, 3661 South Miami Avenue, Miami 33133.

SMA Sponsors Leadership Conference

The Southern Medical Association will sponsor a Medical Staff Leadership Conference at two locations in September and October.

The two day programs are designed to prepare physicians for the responsibilities involved in hospital staff leadership. Each two-day session is acceptable for 11 Elective hours by the American Academy of Family Phy-

sicians, and 11 hours Category I credit toward the AMA Physician's Recognition Award.

The conferences will be held September 17-18 in Nashville, Tennessee, and October 1-2 in Lake Ozark, Missouri. Further information is available from Jeanette Stone, SMA, P.O. Box 2446, Birmingham, Alabama 35201, telephone (205) 323-4400.

Pensacola's Early Hospitals

Elizabeth D. Vickers

Hospital facilities of the 18th and 19th centuries were primitive compared to today's standards. Medical and nursing care was often inadequate; sanitary conditions left much to be desired; patients were hospitalized because they were poor and had no one to care for them at home or because they were homeless; the death rate was high. Little wonder there was a stigma associated with being a patient in a hospital!¹

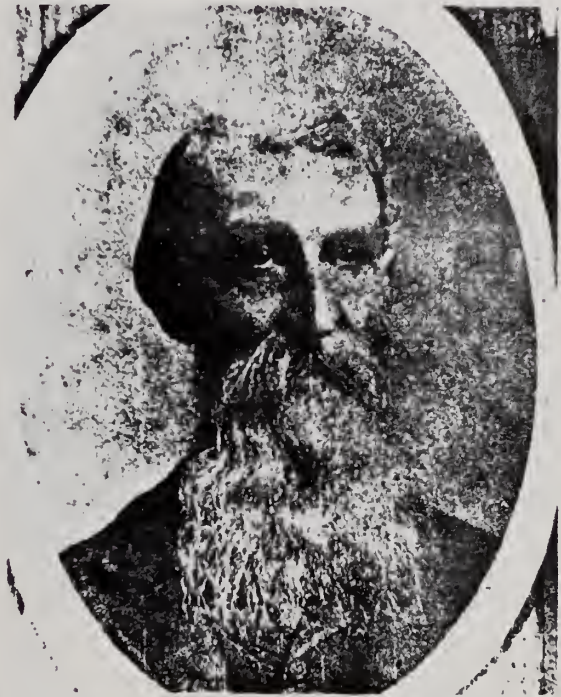
However, the gloomy medical situation of that era was not a static one. In the 1800's medical science began its slow but gradual evolvement into a sophisticated discipline. Hospital designs improved as a result of observations made by Florence Nightingale during the Crimean War and by Americans during the Civil War. The introduction of anesthesia and Joseph Lister's concepts of antiseptics facilitated developments in surgery. Robert Koch's discoveries opened up the field of bacteriology. The American Medical Association was founded and much attention was focused on the education of physicians and on medical licensure laws.¹

The people who needed hospital care the most during this era were often those who could least afford it. The merchant seamen were a significant segment of this medically indigent population. In the 1790's the federal government recognized the situation and one of the first pre-paid medical plans ensued. Congressional action provided for the building of hospitals for the care of the sick and disabled seamen. This hospital construction and medical care was financed through the levy of a monthly tax of twenty cents on the mariners' pay. This salary tax was eventually replaced by a tax on tonnage. These actions signalled the beginning of a system of U.S. Marine Service Hospitals that were administered nationally by the Secretary of the Treasury and locally by the Collector of Customs, an agent of the Treasury Department.²

The Author

MRS. F. NORMAN (ELIZABETH) VICKERS

Mrs. Vickers is a former nurse-educator and previous contributor to *The Journal*. Her husband is Book Review Editor for *The Journal*.



ROBERT B.S. HARGIS, M.D.
PRESIDENT
FLORIDA MEDICAL ASSOCIATION
1882

Dr. Robert B. S. Hargis
1818-1893

Both Spanish and British records attest to the existence of hospitals in Pensacola.³ They were probably little more than places for the sick to lay their heads and receive whatever treatment was available. After Pensacola became part of the United States and a Navy Yard was established, a Naval hospital was built. It was under the command of Surgeon Isaac Hulse. The Naval Hospital has been in continuous operation ever since

except for the period during the Civil War.⁴ The earliest known civilian hospital in Pensacola was started by Dr. R. B. S. Hargis in 1854.⁵

Pensacola's economy was tied to shipping in the 1850's. Anything that affected port activity was of concern to Pensacola's leaders. One of those concerns was the health of the transient population, the merchant seamen who found food, fun and lodging in the cheap saloons and boarding houses along the wharves. Sick seamen brought in contagious diseases; in turn, contagion slowed down or even stopped commercial shipping.

In the 1850's epidemics could ravage an entire population. Pensacola, like other southern coastal cities, had first hand knowledge of epidemics, especially yellow fever. These illnesses stealthily crept in during the hot, summer months, often after the arrival of a ship from a tropical port. Needless to say, Pensacolians were a nervous lot during the summer season. They never knew when the source of their bread and butter might also import the source of their rapid demise.

It was these circumstances which gave birth to a modest hospital in Pensacola. It was a painful birth. Its presence within the city limits was sufficient cause for Pensacolians to initiate legal action against it.

In 1853, Pensacola had two doctors but no marine or civilian hospital. The Collector of Customs traditionally directed sick seamen to the Naval Hospital. However, Josiah Tattnall, the Naval Commandant, called a screeching halt to this unofficial practice. He fired off a letter to the Secretary of the Navy and complained that he had his hands full caring for the population of the Navy Yard and the surrounding villages (Warrington and Woolsey). He was especially angry because Pensacola had taken some strong measures to protect itself against the yellow fever that was then raging all over the Gulf Coast; the city had declared a quarantine and would not allow any vessels from infected cities to come into port. If there were sick men aboard any of these vessels, the quarantine officials directed them to the Navy Yard. He accused Pensacolians of protecting themselves at the expense of the Navy Yard residents and their neighbors.⁶

The Secretary of the Navy responded with a firm decree. He ordered the Commanding Officer of the Navy Yard in Pensacola to receive no merchant seamen into the Naval Hospital except "in case of urgent necessity."⁷

Mr. Joseph Sierra, Collector of Customs, faced a serious dilemma. He urged his superiors at the U.S. Treasury Department to establish a Marine Hospital at this port. Within five months a building at the southwest corner of Palafox and Romana Streets had been leased from Samuel A. Leonard. The rent was \$300 per year. Dr. R. T. Maxwell, a Pensacola physician, offered to serve as the attending physician for an annual salary of \$1,000.

(There is no available documentation that he was appointed to the position.) The hospital was furnished with the basic necessities for a little over \$1,000.⁸ On February 1, 1854, the first U.S. Marine Hospital Service facility was opened in Pensacola, Florida. It closed about six weeks later.⁹

Much to the astonishment of Mr. Sierra and the federal government, the citizens of Pensacola felt that the presence of such a hospital in the center of the city was a menace to the health of the community. A signed petition was presented to the Board of Aldermen. The Board passed a resolution ordering the hospital to close its doors and to move beyond the settled parts of the city.¹⁰

Mr. Sierra was somewhat chagrined since he felt that Pensacolians had been well informed about the hospital plans. April editions of the *Pensacola Gazette* contained editorials and communications from Dr. R. B. S. Hargis (the new young doctor in town) that attempted to allay the fears of the people.

However, the will of the people prevailed and a search was on for a hospital site beyond the populated section of Pensacola. Two buildings were leased in June. They were located on waterfront property in New Town about one mile east of the city, in the vicinity of today's 17th Avenue railroad overpass. Annual rent was \$300.¹¹

The first quarter expenses for the fledgling hospital were \$1,055. This included food for the patients, firewood, horsefeed and the cost of moving from Pensacola. No mention is made of medicines and related supplies!¹²

Misfortune seemed to hover over the marine hospital. Fire, a regular "invader" of the 1800's leveled the dwelling in November 1854. Interestingly enough, Dr. Hargis, the official U.S. Marine Hospital surgeon, had recently established his own private infirmary just forty yards south of the federal facility. Arrangements were

MARINE AND GENERAL HOSPITAL, ON THE BAY, AT THE FOOT OF HERRON'S WHARF, PENSACOLA, FLA.

Seamen treated in hospital, and at office. Dr. C. R. Herron will, if desired, also attend on shipboard.

OFFICE HOURS: From 9 A. M. to 1 P. M. and from 5 to 6 P. M.
DR. JAMES S. HERRON, DR. CHARLES R. HERRON,
Consulting Physician and Surgeon. Attending Physician and Surgeon.

Professional Card
James S. Herron, M.D.
C. 1875

made for him to provide care for the seamen in his hospital.¹³ He charged \$2.50 per day for white patients and \$2.00 for black patients. Surgical operations were extra.¹⁴

On February 13, 1855, fire destroyed Dr. Hargis' private infirmary. However, Captain and Mrs. Scarritt, the owners of the first set of burned buildings, must have rebuilt rather quickly. They were able to offer a small but adequate building for lease and agreed to build an addition to it. The U.S. Government accepted the offer.¹⁵ However, they sternly cautioned Mr. Sierra to hire a watchman to protect the property since fire seemed to be a common occupational hazard.¹⁶

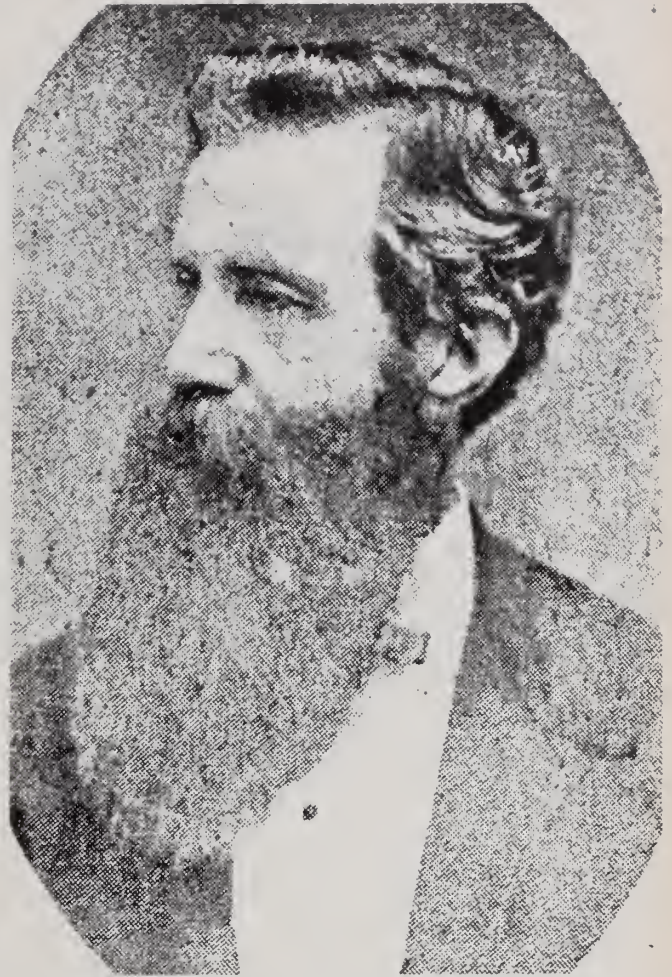
The existence of the Marine Hospital in Pensacola was threatened once again before it was closed by the Civil War. In April 1859, the Board of Aldermen passed a resolution stating that after July 1, 1859, no Marine Hospital could be located within the city limits. The disposition of this resolution is unclear. There is no further mention of it in the correspondence between the hospital and the Treasury Department.¹⁷

What were the administrative problems of a hospital of the era? Mr. Sierra had to contend with Mrs. Scarritt's regular requests for an increase in rent. She usually cited the high cost of living and the high property taxes imposed because of the proposed railroad. The need for supplies was sometimes an urgent issue. Dr. Hargis, the Marine Hospital surgeon, once begged for additional beds. He had 26 patients and only 15 beds. The unfortunate ones had to sleep on straw mats on the floor. The request for additional beds went unheeded for two months before another pleading missive was sent to Washington. The presence of a patient with a communicable disease was cause for much apprehension. In 1856, the Board of Aldermen issued a written order that a patient with smallpox be removed to a house higher up on the hill to prevent him from spreading the disease.¹⁸

There are no records to confirm the continued existence of a Marine Hospital in Pensacola after 1859. There were Congressional considerations to building one, but the proposal was rejected. Pensacola was considered too small a port to justify the expenditure.¹⁹ Thereafter, the care of the seamen was handled on a contract basis with the various proprietary (privately owned) hospitals in the city.

At the end of the Civil War Pensacola had no hospital. The yellow fever epidemic of 1867 forced some action. A temporary hospital for the sick and homeless merchant seamen was established at the northeast corner of Palafox and Romana Streets.²⁰ Interestingly, this Good Samaritan act stirred up no legal opposition, as it had in 1854.

In 1868, Dr. R. B. S. Hargis reopened his private infirmary in New Town,²¹ Dr. James S. Herron bought



Dr. James S. Herron
1835-1915

and established his own hospital in the old Pantan Leslie house located near the southeast corner of Barcelona and Main Streets. One wonders how much competition there was for patients. Dr. Herron later wrote that he built a tunnel from the hospital to the water's edge to facilitate the passage of seamen from the ships.²²

The Treasury Department contracted with Dr. Herron to provide care for the seamen in the 1870's. He charged 95¢ per day for regular illnesses; \$1.90 per day for contagious cases. Burials were \$10. Initially, he received \$6.00 for a burial fee. He complained that the only way he could do it at this price was to get the attendants or the convalescent patients to build the coffins and to dig the graves.²³ The last reference to Dr. Herron's Marine Hospital is in the City Directory of 1885.

In 1884, the Pensacola Infirmary, owned by R. B. S. Hargis, was destroyed by fire. Dr. Hargis suspected arson because threats had been received. He and his son, Dr. Robert W. Hargis, bought 15 acres of land near the old cantonment at the head of Bayou Chico and



Marine Hospital, Pensacola, Florida
James S. Herron, Prop.
C. 1875

proceeded to build a "modern" facility there.²⁴ It cost about \$1400 and promised to be a rather self-sufficient hospital. Plans included digging a well, planting a garden, cutting trees on the property for fuel and raising chickens.²⁵ It is astonishing that, while there are details of the hospital building and its operation, there are no records of medical activity there.

In 1888, the site of the Bayou Chico infirmary became involved in litigation. It seems that the Hargises did not have clear title to the ownership of the property which they eventually lost.²⁵

During the period of dispute the Hargises built another hospital. It was located on Gadsden Street and opened on May 17, 1888. The *Daily News* provided a detailed description:

The location of the new hospital building is on a high ridge, with an open and uninterrupted sweep to the bay front and gently sloping grounds in all directions, giving the inmates full benefit of continuous breezes, with dry and healthy surroundings, aided and assisted by the resinous odor of the surrounding pine, while it is perfectly free from dust, smoke, noise or anything else which could interfere with or annoy the patients.

The buildings were constructed according to the pavilion plan, the latest concept in hospital design. The structures were long and narrow and connected by a covered gallery. There was also a separate operating room and a death house (presumably a morgue).²⁶

One might be tempted to jest about this eloquent newspaper publicity. However, it was probably a very sincere effort to arouse public support of this latest hospital in the community. Dr. Hargis had a serious interest in the science of medicine. He kept detailed

statistics on all the epidemics in Pensacola, attended medical meetings regularly, published articles in the respected medical journals and was active in the American Public Health Association. Hospitals were beginning to develop respectability in other parts of the nation and he probably strove for the same achievement here.

The conscience of the community was regularly nudged by the plight of the poor. In January 1885, the county purchased 60 acres of land about two miles north of the city and erected a poor house. The four buildings included accommodations for white and black patients and living facilities for some of the staff. Dr. F. G. Renshaw was the County Physician and was succeeded by Dr. R. W. Hargis in 1886. Patients were cared for at an average cost of 10¼¢ per day.²⁷ Relatively little is known about this institution. If the published rules and regulations were followed then it was a well disciplined facility. Visitors were allowed twice a week. Inmates had to clean their own rooms, do their laundry, eat their



Dr. Warren E. Anderson
1857-1912



Pensacola Infirmary
323 West Zaragoza
1891

meals in the kitchen if they were able, work on the premises and refrain from swearing and spitting.²⁸

The need for a city supported hospital would not go away. In the fall of 1891, the *Daily News* had several articles about the indigent who were too poor to buy medicines. Various community leaders pledged their support, but that is all it amounted to. Medical care continued to be provided by the privately owned hospitals. In subsequent years the city contracted with these hospitals to care for the indigent.

For 35 years Dr. R. B. S. Hargis had dominated the proprietary hospital field in Pensacola. In 1891, this position of influence shifted to his son-in-law, Dr. Warren E. Anderson. Dr. Anderson and Dr. Frank G. Renshaw purchased the Pensacola Infirmary and relocated it at 323 West Zarragossa Street.²⁹

Running a hospital that catered to the seamen and the indigent was not a very profitable investment. One way to generate operating funds was to appeal to a paying class of patients. A description of the Pensacola Infirmary which appeared in the popular publication, *The Bliss Quarterly*, suggests that its owners had that in mind. The article refuted the idea that this hospital was for the care of seamen only:

On the contrary, the institution has ample accommodations for the very best class of patients, both male and

female, and during the past two years, many prominent citizens have availed themselves of the advantages there offered . . . its popularity is growing so rapidly that the present buildings are inadequate and the proprietors will make extensive additions during the present year.²⁹

The writer continued his "commercial":

[the hospital] is situated conveniently near the business center of the city, upon the very water's edge, where the limpid waves of the beautiful Bay continually break against the shore and where the salubrious breezes from the Gulf of Mexico bring renewed strength and vitality to those in quest of health.²⁹

The next step in developing a quality hospital that would have broad community appeal was to improve nursing care. Drs. Anderson and Renshaw hired Miss F. Elizabeth Crowell to be the hospital Superintendent. Miss Crowell was a graduate of St. Joseph's Hospital and Training School for Nurses in Chicago.³⁰

Miss Crowell must have been an effective Superintendent. In November 1898, the Marine Hospital Surgeon stationed in Pensacola notified the U.S. Treasury Department that Elizabeth Crowell had purchased Dr. Renshaw's half interest in the hospital. She and Dr. Anderson would continue to provide hospital care for the merchant seamen.³¹

At the turn of the century the Pensacola Infirmary "moved uptown." Dr. Anderson and Miss Crowell purchased Winter Rest, a tourist home at the northwest corner of Garden and Baylen Streets.³² It was converted into a forty bed facility and renamed St. Anthony's Hospital. A contract was negotiated with the city and three beds were made available for the care of the indigent. The agreement stipulated that care would be provided at the rate of \$300 for 363 days and \$500 for 730 days.³³

In August 1900, St. Anthony's Hospital incorporated. The capital stock was valued at \$25,000. Dr. Warren E. Anderson, F. Elizabeth Crowell and F. G. Brent were the principal stockholders and the officers of the corporation.³⁴ A training school for nurses was established.

At the end of the first year of operation, St. Anthony's Board of Directors presented an encouraging report. There had been an increase of \$1,000 in the capital stock and an undivided profit of \$2,826.89. Patient admissions were up by 11%. The demand for trained nurses for cases outside the hospital continued to increase. This was attributed to the public's realization of the necessity of intelligent, trained nurses in all cases of serious illness.³⁵

St. Anthony's most outstanding contribution to the community probably occurred during the yellow fever epidemic of 1905, when they implemented some of the latest concepts of yellow fever control. By careful screening they kept mosquitoes out of the hospital. The non-immune nurses (ones who had never had yellow fever themselves) cared for yellow fever patients and did not contract the disease themselves. Dr. Joseph Y. Porter, the Florida State Health Officer reported that this had successfully demonstrated that yellow fever could be controlled by the exclusion of mosquitoes.³⁶

The triumphant mood for a job well done at St. Anthony's soon collapsed. Most of the work during the yellow fever epidemic had been with the poor and the homeless. In January 1906, the stockholders voted to liquidate because "... the large amount of charity work in the city makes it impossible to conduct an institution of this kind on a self-sustaining basis."³⁷

Was the financial drain of charity work the sole reason for the financial failure of St. Anthony's hospital? Did competition for paying patients play a role?

It is interesting to note that in 1903 Dr. Robert Lee Bryans operated a sanitarium on the southwest corner of Garden and Baylen Streets, directly across the street from St. Anthony's. Fire destroyed the sanitarium on January 14, 1903. One patient died in the blaze.³⁸

Dr. Bryans reopened his hospital at 100 East Wright Street.³⁹ In 1907 it was located at 928 East Gadsden Street.⁴⁰



F. Elisabeth Crowell
1880-1950

Dr. Anderson was persistent in his efforts to maintain a hospital for Pensacolians. Sometime after the closing of St. Anthony's he opened a hospital on North Hill. It was known as the Pensacola Hospital and Training School for Nurses and was located at the corner of Reus and Strong Streets.⁴⁰ It was absorbed by the Pensacola Sanitarium which opened in 1909.

The establishment of the Pensacola Sanitarium marked the beginning of another era in the history of Pensacola hospitals.

Initially the need for a hospital revolved around the care of sick seamen, an effort pioneered by Dr. Robert B. S. Hargis. This was followed by the slow but noticeable trend to shape the hospital into an institution that would serve the entire community, not just the poor and the homeless. Locating the hospital in a desirable section of town was the first step. Establishing a comfortable tie with the community by training nurses who could provide good nursing care in the hospitals and in homes was the



St. Anthony's Hospital and Sanitarium

AND
Training School for Nurses.

104 WEST GARDEN STREET,
PENSACOLA, FLA.

Dr. Warren E. Anderson,
Surgeon in Charge.

F. Elisabeth Crowell,
Superintendent

STAFF OF PHYSICIANS.

★ Dr. Warren E. Anderson	Dr. F. G. Renshaw
Dr. H. L. Simpson	★ Dr. J. Whiting Hargis
Dr. J. H. Pierpont	Dr. H. J. Wright
★ Dr. S. R. M. Kennedy	Dr. D. W. McMullan
★ Dr. E. F. Bruce	Dr. L. DeM. Blocker
Dr. C. W. D'Alemberte	Dr. F. M. Thigpen

Cover of Brochure for St. Anthony's Hospital
1900-1906

next step. Dr. Warren E. Anderson was the undisputed local leader in this phase of hospital development.

By 1909 the medical profession had achieved remarkable improvements. The medical education of the physician had been upgraded. Hospitals were assuming a more responsible role in the delivery of health care. Laboratory and x-ray services were being used in the diagnosis of illnesses. New understanding about the prevention of certain illness gave impetus to more effective public health laws. States were enacting medical licensure laws.¹

The one aspect of hospital history that had failed to keep pace with all the other maturing processes was the public's acceptance of hospitals as respectable places to go for medical treatment. In 1911, Mission Hospital, a small missionary supported facility on North Hill, announced that it was changing its name to St. Luke's Hospital. Paying patients were reluctant to go to a

St. Anthony's Hospital and Sanitarium and Training School for Nurses.

WE desire to call the attention of the public at large to our recently increased facilities for the care of the sick by the opening of a Training School for Nurses in connection with our institution. We have hitherto been hampered in our work, outside as well as inside of the hospital, by our inability to secure a sufficient number of competent nurses. This condition we have sought to remedy by the establishment of our Training School. The pupils are young women of the highest moral character and possess the requisite amount of education. The opportunities offered them for clinical experience will be ample, their practical training will be in the hands of a competent graduate nurse and our staff of physicians will deliver various courses of lectures on the subjects pertaining to their profession, during the two and half years of training.

Our hospital is open for the reception of both surgical and medical cases. Physicians out of town are invited to send in those cases requiring hospital treatment, and we shall be glad to have them accompany such patients, assuring them that every courtesy will be extended to them by both the hospital and its staff of physicians.

For further information and terms, apply to the Superintendent

Lectures of the Training School for Nurses.

Hygiene—Materia Medica—Therapeutics,	Dr. Warren E. Anderson
Anatomy,	Dr. F. G. Renshaw
Physiology,	Dr. S. R. M. Kennedy
Gynaecology,	Dr. J. H. Pierpont
Obstetrics,	Dr. J. W. Hargis
Fever—Dietetics,	Dr. H. J. Wright
Surgical Nursing—Abdominal Surgery,	Dr. H. L. Simpson
Special Medical Nursing—Electro and Hydro—Therapeutics—Massage,	Dr. D. W. McMullan
Nursing in Infante and Children's Diseases,	Dr. E. F. Bruce
Nursing in Nervous Diseases,	Dr. L. DeM. Blocker
Minor Surgery—Anaesthesia—Bandaging,	Dr. C. W. D'Alemberte
Nursing in Diseases of the Eye, Ear, Nose and Throat,	Dr. F. M. Thigpen

Inside of Brochure for St. Anthony's Hospital

hospital that catered to charity patients. Since the financial support of paying patients was needed, the owners thought a name change might create a more positive image. Apparently, it was not an effective measure. Mission Hospital quietly faded from the hospital scene and its ultimate fate has not been determined.⁴¹

All the positive developments were bound to have a rippling effect which would inevitably reach small communities. Pensacola was no exception.

A group of nine Pensacola physicians formed a corporation in 1909 and opened the Pensacola Sanitarium at the corner of Garden and DeVilliers Streets. The capital stock was \$20,000.⁴²

The president of the hospital corporation, Dr. Clarence E. Hutchinson, had impressive credentials. He had graduated from Tulane Medical School in 1905 and subsequently was appointed Assistant House Surgeon and then Senior House Officer at the Touro Infirmary, a 200 bed hospital in New Orleans. Both of these appointments were paid staff positions. In 1907 he was appointed Superintendent of Touro. Prior to his return to Pensacola he studied in Vienna and in England.⁴³

The Sanitarium staff invited Pensacolians to an open house on January 14, 1909, and the response was enthusiastic. The modern facilities were impressive; an x-ray room, a laboratory complete with "freezing apparatus for the examination of tumors, excretions and pathological specimens," an emergency room, an operating room and a scrub room. The two-story structure had an elevator and could accommodate 20



Pensacola Sanitarium
West Garden Street
1909-1915

patients. Miss DeWitt Dillard and six nurses came from Touro to provide nursing services. Miss Dillard was also responsible for the training school for nurses.⁴⁴

The Pensacola Sanitarium served Pensacolians until 1915. Then it closed its doors to make way for a bigger and better equipped hospital.

As the need for a community hospital continued to expand so did the necessity for greater community involvement in its development and financial support. A group of Pensacola's medical, lay and religious leaders invited the Sisters of Charity of Emmitsburg, Maryland, to come to Pensacola. That was the beginning of the Pensacola Hospital (now known as Sacred Heart Hospital) and another era of hospital history.⁴⁵

The history of Pensacola hospitals is rather remarkable. In its infancy the hospital concept was so repugnant that the physical facility was forced to locate in an isolated spot. Pushing it out of sight was the next best thing to pushing it out of existence. In a little more than a half century the changes in medical science and public attitudes enabled Pensacolians to welcome the hospital

as a respectable and permanent community institution. It received financial support and assistance from the city's leaders and it was permitted to locate in a respectable residential neighborhood.



Dr. Clarence E. Hutchinson
1915

References

- 1 Bordley, James III, M.D.: *Two Centuries of American Medicine*, Philadelphia, W. B. Saunders Co., 1976.
- 2 Thurb, Richard H., M.D.: "Early History of the U.S. Public Health Service (Marine) Hospitals: The First Federal Prepaid Medical Care Plan," *The Mount Sinai Journal of Medicine*, N.Y., Vol. 37: July-Aug. 1970.
- 3 McGovern, James R., Ed.: *Colonial Pensacola*, Vol. 1, Pensacola, Tom White the Printer 1972.
- 4 *The U.S. Naval Hospital Pensacola, Florida and Its Historical Heritage*, The Hospital Welfare Department, Jan. 1946.
- 5 Joseph Sierra to James Guthrie, Sec., Treas., Nov. 3, 1854, Letters on Marine Hospitals, 1854, Public Health Service, Record Group 90, the National Archives, Washington.
- 6 Josiah Tattnall to James C. Dobbin, Sec. Navy, August 18, 1853, Letters on Marine Hospitals 1853, Public Health Service, R.G. 90, The National Archives, Washington.
- 7 Joseph Sierra to James Guthrie, Sept. 7, 1853, Letters on Marine Hospitals, 1853, Public Health Service, R. G. 90, The National Archives, Washington.
- 8 Joseph Sierra to James Guthrie, November 25, 1853, Jan. 10, 1854; Letters on Marine Hospitals, 1853-1854, Public Health Service, R. G. 90, The National Archives, Washington.
- 9 *The Pensacola Gazette*, March 18, 1854, and April 22, 1854.
- 10 Resolution of Board of Aldermen, City of Pensacola, March 20, 1854. Letters on Marine Hospitals, 1854; Public Health Service, R. G. 90, the National Archives, Washington.
- 11 Lease Agreements Between Henry Ahrens and Joseph Sierra, Collector of Customs; and Henry F. Ingraham (Agent for Capt. J. W. Scarritt) and Joseph Sierra. Pensacola, Fla., June 1, 1854.
- 12 Joseph Sierra to H. J. Anderson, Commissioner of Customs, June 26, 1854, Letters on Marine Hospitals, 1854, Public Health Service, R. G. 90, the National Archives, Washington.
- 13 Joseph Sierra to James Guthrie, Nov. 3, 1854, Letters on Marine Hospitals, 1854; Public Health Service, R. G. 90, the National Archives, Washington.
- 14 *The Pensacola Gazette*, October 28, 1854.
- 15 Joseph Sierra to James Guthrie, Feb. 13, 1855, Letters on Marine Hospitals 1855, Public Health Service, R. G. 90, the National Archives, Washington.
- 16 Joseph Sierra to James Guthrie, March 14, 1855, Letters on Marine Hospitals 1855, Public Health Service, R. G. 90, the National Archives, Washington.
- 17 C. Gonzalez, Mayor of Pensacola, to Joseph Sierra, May 25, 1859, Letters on Marine Hospitals, 1859, Public Health Service, R. G. 90, the National Archives, Washington.
- 18 Letters on Marine Hospitals, 1855-1859, Public Health Service, R. G. 90, The National Archives, Washington.
- 19 First Annual Report of the Supervising Surgeon of the Marine Hospital Service of the U.S., Washington, G.P.O. 1872.
- 20 *The Pensacolian*, Jan. 5-6, 1884.
- 21 Rerick, Rowland H.: *Memoirs of Florida*, edited by Frances P. Fleming, Atlanta, Ga., Southern Historical Association, 1902.
- 22 Herron, James S.: "Complete and Authentic History of Pensacola," *Pensacola Evening News*, June 26, 1909.
- 23 Secretary of the Treasury to Collector Customs (Pensacola) Aug. 27, 1874, Letters on Marine Hospitals, 1874, Public Health Service, R. G. 90, The National Archives, Washington.
- 24 *The Pensacolian*, April 26, 1884.
- 25 Escambia County Court Record 1888-9211, Walter Tate vs. Pensacola & Land Development Co., Jan. 24, 1889.
- 26 *The Daily News*, Aug. 18, 1888.
- 27 *The Daily News*, Feb. 14, 1890.
- 28 *The Daily News*, July 15, 1896.
- 29 *Bliss Quarterly*, Vol. III, Pensacola, Jan. 1897.
- 30 Hess, J. William, The Rockefeller Foundation, N.Y., to Elizabeth Vickers, August 11, 1972.
- 31 J. Whiting Hargis, M.D. to Dr. Walter Wyman, Supervising Surgeon General, M.H.S. Nov. 28, 1898, Public Health Service, General Subject Files—1897-1923, File #449, Box 60.
- 32 *The Daily News*, Jan. 22, 1900.
- 33 *The Daily News*, March 9, 1900.
- 34 Incorporation Record, Book #1, Escambia County Court House, pp 197-200, Sept. 18, 1900.
- 35 *The Daily News*, Nov. 7, 1901.
- 36 Porter, J. Y.: "Yellow Fever in Tampa and Pensacola, Fla. 1905," Report of the Surgeon General of the U.S.P.H.S. and M.H.S. for 1906-1907, Washington, 1907.
- 37 *The Pensacola Journal*, Jan. 17, 1906.
- 38 *The Daily News*, Jan. 14, 1903.
- 39 Pensacola City Directory, Vol. II, Pensacola, R. L. Polk & Co., Publishers, 1905.
- 40 Pensacola City Directory, Vol. III, Pensacola, R. L. Polk & Co., Publishers, 1907.
- 41 *Pensacola Journal*, November 5, 1911.
- 42 Incorporation Record, Book #2, Escambia County Court House, pp 423-26, Feb. 27, 1909.
- 43 Jane Hutchinson McRoberts to Elizabeth Vickers, October 19, 1980.
- 44 *The Pensacola Journal*, January 14, 1909.
- 45 *The Pensacola Journal*, September 2 and September 9, 1915.

• Mrs. Vickers, 3720 McClellan Road, Pensacola 32503.

Erratum

The article, "Potassium Supplementation: Comparative Studies in Edematous and Non-edematous Patients" (JFMA, January 1981) stated that patients received a glass of orange juice that contained 100 ml of juice. The correct amount of juice in each serving is 240 ml.

Florida and the Spanish Flu

William M. Straight, M.D.

With 679 new cases of influenza reported and sixteen deaths in the twenty-four hour period ending at 10 o'clock yesterday morning the epidemic in Tampa does not seem to be subsiding to any considerable extent, and with the development of new cases the needs of the sick are becoming more numerous; attention for them is harder to find and some of the scenes in Ybor City among afflicted people in poor circumstances are pitiful to the extreme . . . Only a personal visit among the suffering people of the poorer sections of the city can impress the outsider with the gravity of the situation there. Yesterday one family consisting of mother and father and seven children were found on Fourteenth street who were all ill: three of them with pneumonia, others with the lungs affected, everyone of them in serious condition. Doors and windows of the house were closed tight and burlap sacks were placed at the cracks to keep out every vestige of air. The mother and two little girls were in one bed, a very sick baby in a crib nearby, the father with temperature of 103 dressed and sitting in a chair, trying as best he could to administer to the wants of his stricken family. A sour bottle of milk was the only food in the house for the baby, a little ten-months-old thing, underfed, thin, and racking from head to toe with a terrible cough, stricken with pneumonia and not expected to live . . . The ambulance answered a hurry-up call and five members of the family were rushed to the emergency hospital. The mother went into a fit of hysterics as she saw the gray automobile roll away from the house with her husband, her little baby and three other children. She cried and had to be held down.¹

One of the grimmest cases reported during the epidemic involved the poverty-stricken Logan family, twelve of whom lived in 'a two-room hut' in the suburb of Panama (near Jacksonville). Nine of the Logans were gravely ill with the flu when their plight was discovered by relief workers on October 23. One child was dead of influenza, two babies were near death from starvation, three children were suffering with double pneumonia, and the others were weak from exposure and malnutrition. Two of the Logan girls, each about 112-years-old, were trying to care for the family but could do little since there was neither food, drugs, nor 'the simplest comforts' in the hovel.²

The Metropolis reported that, "the Board of County Commissioners being advised of the instance, had the little fellow buried and four of the worst cases taken to the County Hospital, while four of the small children are now in the County Home."²

The Author

WILLIAM M. STRAIGHT, M.D.

Dr. Straight is engaged in the private practice of Internal Medicine, and is Historical Editor of The Journal.

Poignant scenes such as these became commonplace throughout Florida during the month of October 1918. The Spanish influenza was so named because it was first widely publicized from Spain in May and June of 1918. In truth this disease had appeared at Camp Funston, Kansas, on March 4, 1918.³ About this time there were also cases reported among factory workers in Detroit and the prisoners at San Quentin. Just where or when the first case appeared is unknown. One thing that is well-known is the alarming rapidity with which it spread even to semi-isolated communities. Studies after it was all over suggest that over one quarter of the U.S. population, twenty-five million or more people, had overt flu in the fall of 1918 and winter of 1919. Approximately 550,000 Americans died of the flu and its attendant pneumonia during those few weeks. As the epidemic was world-wide it has been estimated that between twenty and forty million people died.⁴

The Spanish influenza appeared in Florida almost simultaneously with its appearance in Boston and along the northeastern Atlantic coast. It was first recognized among the personnel at the United States Naval Air Station at Pensacola on September 11, 1918.⁵ Soon after this, on September 19th, the Jacksonville health authorities published the following: ". . . there are a number of such cases (Spanish influenza) here . . ."⁶ Thereafter news reports of the disease appear from various parts of the state in rapid succession: September 20th — St. Petersburg and Gainesville; September 22nd — Tampa; September 28th — West Tampa; September 29th — Pensacola; October 5th — Arcadia; October 7th — St. Augustine, Plant City and Miami; October 8th — Tallahassee; October 9th — Quincy, Ocala, Orlando and Kissimmee; October 11th — DeFuniak Springs, Milton, Crestview, River Junction and Lakeland, and on and on. Almost no spot in Florida was spared.

It is impossible to determine just how many Florida residents came down with the flu for it was not a reportable disease. In the metropolitan areas usually after the epidemic had made significant headway the health departments requested that physicians report all cases they attended. However, this request was not well complied with because the doctors were overworked and keeping records seemed of secondary importance. We

do have reasonably accurate statistics of the deaths as each of these had to be reported to the State Board of Health by the mortician:⁷

September	85
October	2712
November	934
December	383
Total	4114

When tabulated according to sex and color, male whites seem to have suffered most:

	Total	Male	Female
Total	4114	2323	1791
White	2378	1434	944
Black	1736	889	847

When the nation-wide statistics were tallied, the age incidence showed three peaks: children under five, adults between 25 and 34, and a low peak for adults over 65. This pattern was not so evident in Florida. The death rate among females exceeded that of males up to age 24, but the males died more frequently than the females from age 25 to 45 years. The death rates of black and white females were almost identical at all ages, but the white male died more frequently than the black male. This latter finding was explained by the hypothesis that blacks being more susceptible, experienced the milder flu of the spring of 1918 and built up immunity to the severe form.

Throughout the country the Indians suffered severely and displayed a mortality rate four times that of people in the large metropolitan areas. A report of the Office of Indian Affairs for the period October 1, 1918, to March 31, 1919, states that of the 585 Indians living in Florida 66 came down with influenza and ten died giving a case fatality rate of 15%.⁸

Jacksonville

Not since the yellow fever epidemic of 1888 had the people of Florida experienced such a devastating epidemic. The Jacksonville historian, T. Frederick Davis, describing the flu onslaught in Jacksonville found the two epidemics similar but noted: "The rattle of the death carts of 1888 was supplanted by the whirl of the motor in 1918, as the trucks took their loads away."⁹ Jacksonville's newspaper, *The Florida Metropolis*, on Thursday, September 19th, carried a message from the City Health Officer: "People of Jacksonville are advised by health

authorities of the city to be on the lookout for Spanish Influenza as there are a number of such cases here . . ."⁶

The following day the paper noted cases of Spanish flu at Camp Joseph E. Johnston, near Jacksonville, but denied the existence of a flu epidemic in Jacksonville. Lieutenant Colonel Joseph Yeates Porter, Camp Surgeon at Camp Johnston, reporting to the Commanding Officer noted: "During the past four days an increased number of cases of Influenza have developed in this camp amounting and increasing to date, 158 cases, which assumes the phase of an epidemic." He goes on to note that it had appeared spontaneously and generally throughout the camp and was undoubtedly brought by troops "reaching here from all parts of the United States."¹⁰

At first the newspaper mentions occasional cases such as members of the city's governing board becoming suddenly ill but as late as September 25th, the paper maintains there is no epidemic. By October 3rd, the paper admits, "the Spanish Disease is making headway here," and notes that St. Luke's Hospital is overflowing with influenza cases. The newspaper regrets that so many of the paper carriers are ill it cannot guarantee delivery to homes. The ice companies have, "so many of the old men who are employed as firemen and ice pullers, etc., sick . . ." that their production capacity is down fifty percent. The Jacksonville Traction Company, operators of the streetcar system, have just employed Mrs. Anna H. Willoure, "the first female conductor the company has ever had." This move had been planned as part of the war effort but as the company had 125 men out with the flu, the plan was implemented early. The Purity Ice Cream and Dairy Company notified its customers that because of the widespread illness they could not assure home delivery for the present. By October 5th, the paper noted that many doctors and nurses were ill and unable to tend the sick. On October 7th, the Jacksonville schools were closed and the following day soft drink stands, pool rooms, dance halls, theaters and all places of amusement were closed. The shipyards, perhaps the most thriving industry in wartime Jacksonville, reported absentee rates amounting to a quarter to two-thirds of their employees. Because so many pharmacists were ill the City Physician, William W. MacDonell, asked physicians to write only short prescriptions.

Although the paper kept trying to reassure the people that things were in hand, obviously the epidemic was progressing apace. A plea for volunteer nurses was published with the note, ". . . in a great number of cases whole families are confined to their beds . . . it is impossible to get nurses in Jacksonville." The peak of the epidemic was reached about October 13th, on which day there were thirty-nine deaths. At this time both the St. Luke's Hospital and the Duval County Hospital were

filled to overflowing with extra beds in the wards and on the verandahs. Duval County Hospital reported that all but two of their nurses and the physician in charge, Dr. Louis Stinson, have been ill. The Young Mens Christian Association opened seventeen beds in their gymnasium and the Young Mens Hebrew Association made twenty-five beds available in their club rooms. For the blacks an emergency hospital of twenty beds was set up at the Stanton School with Brewster Hospital supplying the nurses. At this time the City Physician estimated there had been 20,000 cases of flu in Jacksonville since its first appearance, and 73 deaths from the flu between October 1st, and October 11th. Five days later the death toll had grown to 215 (105 whites and 110 blacks) but few new cases were being reported to the city board of health.

Gradually the epidemic began to subside, first among the whites and later among the blacks. On October 23, *The Metropolis* jubilantly headlined, "No Deaths From 'Flu' Reported." However, this was not the last of the flu for by the end of October the City Physician estimated at least 30,000 Jacksonvillians had suffered the flu and 464 had died.¹¹

Tampa

The Spanish Influenza or SPIF, as a Tampa newspaper reporter dubbed it, appeared in Hillsborough County about September 22nd, when Jesse Wheeler of Dover came home sick from an army camp in Virginia. The camps in Virginia were rife with flu and the camp hospitals overflowing. Faced with inability to adequately care for the sick, the camp commanders began sending the men home as soon as they showed the first sign of illness. Wheeler, just eighteen years old, contracted double pneumonia soon after arriving home and on September 29th, became the first fatality from the flu in Hillsborough County.¹²

As elsewhere in Florida, at first the newspaper played it down reassuring the people that in Tampa the flu was mild and there was no need to be alarmed. Nevertheless the SPIF would not go away and by October 9th it was estimated there were 3000 cases in Tampa. The Railway Express had so many of their personnel sick that they announced in the paper they could handle only perishables and goods related to the war effort. The schools were closed and many businesses and factories closed. By October 15th, 700 new cases were reported during the previous twenty-four hours — 430 in Ybor City. Tampa Electric Company reported one third of their workers out and the Tampa Police and Fire Departments were crippled by lack of personnel. Drug stores were having difficulty handling the calls for medicines and all food and drink stands "without adequate sterilizing facilities" were closed. An emergen-

cy hospital with an ultimate capacity of one hundred opened at the Fair Grounds on the 16th. Three days later (October 18th) the previous twenty-four hours had yielded 712 new cases with eighteen deaths. In some sections of the city the paper reported from two to six people sick in every home. Five hundred women were needed immediately to nurse the sick. A tent hospital was opened on the grounds of the Hillsborough High School to care for sick males only, but the peak was yet to come.

The twenty-four hours, October 21st to October 22nd, produced 1,022 new cases with twenty-two deaths. At this point the epidemic was raging hottest in Ybor City necessitating the opening of an emergency hospital in the Circulo Cubano Building on October 23rd. The paper deplores the lack of interest among the Latins in the opening and staffing of this facility. The Red Cross Headquarters was receiving three calls for help to every one they had sufficient personnel to answer. One cigar factory had shut down its operation and the Cuesta Ray Cigar factory had produced only 20,000 cigars per day during the previous two weeks whereas its usual production was 90,000 cigars per day.

After October 23rd, the epidemic in the Tampa area began to abate slowly. Ybor City and West Tampa lagged behind the city of Tampa; it died out last in West Tampa. On October 27th, for example, another emergency

SHERMAN'S Influenza Vaccine No. 38

Will abort Colds, Grippe, Influenza
and Pneumonia.

EACH MIL. CONTAINS

Influenza B. strains from present epidemic and others	200,000,000
Streptococci, many haemolytic and other types	100,000,000
Pneumococci, type 1, 2, 3 and 4, in proper proportions	100,000,000
Micrococcus Catarrhalis, leading members of the group	200,000,000
Staphylococcus Albus, many strains ..	200,000,000
Staphylococcus Aureus, many strains ..	200,000,000

This Vaccine is also used with success in the prophylaxis of these diseases.

WRITE FOR REPORT
on 300,000 INOCULATIONS of
INFLUENZA VACCINE
in the present epidemic.

G. H. SHERMAN, M. D.,
DETROIT, MICH., U. S. A.

Advertisement appearing in *The Journal of the Florida Medical Association*, 1918.

hospital had to be opened in Ybor City — at the San Marco Club on 6th Avenue. On October 28th an emergency hospital was set up in the post office building in West Tampa. Nurses continued to be in great demand and there is a note about one street in Ybor City on which there were fifty cases of SPIF with no one to nurse them. By October 31st, apparently the authorities were in agreement that the flu epidemic was definitely on the wane. Many businesses and places of amusement had reopened and the Tampa Electric Company reported that more than half of their employees were back on the job. Schools finally reopened on November 11th. The city board of health released the following statistics on November 4th covering the period, October 9th thru October 31st: "Tampa physicians attended 19,170 cases of influenza." There were 278 deaths attributed to the flu and its attendant pneumonia giving a mortality rate of 1½% of the total reported cases.¹³

Pensacola

The first admission of the presence of the Spanish influenza at Pensacola appears in *The Pensacola Journal* on Monday, September 29, 1918, and the article notes that it was epidemic at that time and implies it had been around for more than two weeks.¹⁴ In that same issue it is noted that thirty-five motormen and conductors of the Pensacola Electric Company, which operated the streetcars, were ill and services were curtailed. The following day the school board announced an indefinite delay in the opening of school. Over the next several days articles appeared stating that the onslaught of the flu was seriously hampering the Liberty Loan workers, many businesses, the telephone service (only the most urgent calls could be handled), the police and the public transportation. On October 4th, only eighteen of 102 employees were on duty at the Pensacola Electric Company. Doctors interviewed by the newspaper reported they were receiving one hundred calls a day. Whole families were sick with no one to nurse them; one recently arrived family, a mother, father and two young children were found dead in their home.¹⁵ By October 5th, all places of amusement were closed and churches had voluntarily agreed not to hold services lest such public gatherings spread the flu. An appeal went out for nurses, doctors and pharmacists. Among those who responded were eight Red Cross Nurses from Marianna, several doctors from the United States Navy Yard at Pensacola and Fort Barrancas, and Dr. J. A. Wells, the quarantine officer at the port of Panama City. The thirty year old Wells acquired the disease during the epidemic and died at The Pensacola Hospital on October 22nd. On October 8th, the number of cases was still increasing and The Pensacola Hospital which customarily accomodated

forty-eight patients was trying to care for 101 patients with only six nurses able to be on duty.¹⁶ The Pensacola Emergency Relief Committee was swamped with calls for assistance; on October 9th, they received 375 calls of which 75 could not be responded to for lack of personnel.

In the October 13th issue, the *Journal* confidently proclaimed the epidemic practically stamped out but it didn't go away that easily. The Pensacola Hospital was still overloaded and an eight-bed emergency hospital at The Patriotic League Rooms was constantly full. Nevertheless the doctors were getting fewer calls; Dr. Louis deM. Blocker commented that for the first time since the epidemic began he could eat his meals when he wanted to. As late as October 26, new cases of flu were being reported and deaths from the flu were occurring. Indeed, the flu continued to linger in Escambia County in sufficient severity to hamper businesses as late as December 15th.¹⁷ Just how many Pensacolians suffered the Spanish influenza and how many died of it and the attendant pneumonia, no one can say with certainty. The only published statistics are the result of a poll of the Pensacola undertakers' by a reporter of the *Journal* on October 22nd. Deaths from all causes during the epidemic up to that time were 171 of which 108 were white and 63 were black. Among the army and navy personnel there were 60 deaths and from the towns in the vicinity of Pensacola another 32 deaths.

The Smaller Cities and Towns

The morbidity and mortality statistics in the smaller cities and towns are even less reliable than in the big three cities but it is evident that many of these suffered severely. Flu was present in Gainesville as early as September 20th and rapidly spread from the town to the University of Florida campus. The first death occurred in the town in October 2nd and was quickly followed by others. Five University of Florida students died and there were "hundreds of cases" on the campus. The seats in the chapel were removed, numbered cots set up and three Red Cross nurses were brought in to nurse the sicker ones. In the town, schools, places of amusement, businesses and churches were closed from October 5th to October 19th. Indeed, things did not get back to normal until about October 26th.

The nearby towns of High Springs, Newberry and Hawthorne all suffered sorely. In High Springs on October 9th, 160 new cases had appeared in the preceding twenty-four hours, there were 60 cases among the railroad shop employees alone, two of the towns druggists were sick and the town's only physician, Dr. C. McK. Tyree, was in bed with pneumonia. Also in Hawthorne and Newberry the only physicians in town were sick and there were many cases of the flu.

Although Ocala seems to have had but few cases, not far distant Dunnellon had a terrible seige. County Judge E. C. May records more than one hundred deaths in Citrus County with no more than 5,000 inhabitants. He also comments that most of the deaths were among heads of families and recalls the following example: "Soon after that the wife of Jesse Smith, a rich cattleman from the Red Level district, died and I appointed Jesse as administrator of her estate. He died before he could qualify and I appointed the husband of their daughter administrator of both estates. But he did not live to qualify. I then appointed Art Smith, the brother of Jesse, administrator of all these estates and he died before he could file his bond. Then there was not a man left in these families and I had to go outside for representatives to settle these estates."¹⁸

Apparently there were many cases at Dade City, Plant City, and Tarpon Springs but few cases at St. Petersburg. The mortality was low in all of these places. At Clearwater officials refused to allow admission of flu cases to the principal hospital, The Morton Plant Hospital, but fitted up an emergency hospital at another spot. At Sutherland (current day Palm Harbor), then the home of Florida Southern College, there were over one hundred cases and one death. Back on the east coast, DeLand, the site of Stetson University, apparently suffered several deaths and nearby New Smyrna was hard hit. So also was St. Augustine, but the school for the deaf and blind escaped completely when Dr. Walker refused to allow anyone to enter or leave except on the most necessary business.

At Tallahassee there were a number of cases with several deaths. Among the 550 member student body at the Florida State College for Women there were 61 cases and no deaths. Further west into the panhandle, Quincy was perhaps the hardest hit of the small cities. By October 9th, there were more than 500 cases in Quincy and all places of public gatherings were closed. Four days later there were more than 1000 cases and two of the town's five doctors were sick.¹⁹ Six days after that Gadsden County had 3000 cases and all but one of the doctors practicing in the county were sick. So grave was the situation that the United States Public Health Service dispatched a doctor from Newnan, Georgia, to help in the crisis. In the October 27th edition of the *Journal* the reporter notes that the epidemic at Quincy was under control but that the toll among the town's young men was "most deplorable" and that over 100 Negroes had died in and around Quincy. He also noted that during the height of the epidemic all business had been suspended except the dispensing of medicines and the making of caskets.

At the Army Camps

The armed services had a number of establishments

in Florida including five of the army's thirty-five flying schools. The largest of these establishments was the Auxiliary Remount Depot 333, also known as Camp Joseph E. Johnston, on the site of the present Jacksonville Naval Air Station. As previously mentioned, Camp Surgeon, J. Y. Porter, reported to his camp commander on September 19th, that influenza cases had been increasing in number "during the past four days." In his final report of the epidemic Porter states the first case appeared about September 18th and the last case was cured about November 1, 1918. The number of cases at Camp Johnston mounted rapidly reaching a peak of 300 new cases per day admitted to the base hospital on October 3rd, then began declining until on October 20th only 31 new cases were admitted. During the course of the epidemic 20% of the hospital's officers, 25% of the hospital's enlisted men and 50% of the nurses, "... were sick with Influenza or Broncho-pneumonia."²⁰ The Camp Surgeon, himself, came down with the flu on October 11th and was unable to "again resume the duties of his desk until November 4th."

According to Surgeon Porter the mean strength of Camp Johnston for October 1918 was 18,074 men. The total number of influenza cases was 2,575.²¹ Thirty percent of those with influenza developed pneumonia (785 cases).²² Porter reports a total of 165 deaths attributable to the flu and attendant pneumonia. This will give a mortality rate of 6.4% of all the influenza cases and of 21% of all the pneumonia cases. He also notes that although the black troops developed pneumonia more frequently than did the white troops, they died of the pneumonia less frequently. This difference in mortality was observed throughout the army.²³

Although there are sketchy reports extant of the Spanish flu at the Aerial Gunnery School, Chapman Field and the Naval Air Training School at Dinner Key, all in Dade County, and a mention of 42 cases of influenza at Carlstrom Field near Arcadia, the only other useful statistics from armed forces installations of Florida come from the U.S. Naval Air Station at Pensacola.⁵ On September 11, 1918, the navy announced the flu had killed 26 sailors in and around Boston and had been recognized among navy personnel in seven states one of which was Florida.²⁴ This referred to the Air Station at Pensacola.

The air station had a total of 5,359 men and suffered 1,454 cases of influenza (27% of the station's personnel) between September 11th and October 27, 1918. Seventy percent of these cases occurred in the thirteen days, September 22nd through October 4th. The peak day for admissions to the sick list was September 30th with 117 cases admitted. The epidemic was thought to be under full control on October 27th. There were 24 deaths among the influenza victims; giving a death rate of 1.6%.

PANOPEPTON

Has been of great service in this epidemic Influenza-Pneumonia.

It has been thus extensively resorted to because of its long proven value in the every-day therapeutics of feeding.

Panopepton has *always* contained the entire digestible substance of the whole wheat berry and entire lean beef as obtained under the regulated action of stomach and pancreas gland tissue juices in order to convert and set free all the complex basic proteins and carbohydrates and associated organic and inorganic constituents—minute, but of *vital importance*.

The highly diversified nitrogenous substances are in a non-coagulable, highly diffusible and assimilable form and in great part consisting of amino-acids, the ultimate cleavage products.

Panopepton is a completely and quickly assimilable dynamic food of remarkably nourishing and restorative properties, a proven resource in depressing, exhausting disease.

Panopepton is a substantial food—24 per cent of actual food solids in a standardized, balanced ratio, nitrogenous and carbohydrate.

Panopepton is found personally useful by the physician himself in these arduous days of fatigue and deprivation of sleep.

We shall be pleased to send Panopepton to any physician—upon request.

FAIRCHILD BROS. & FOSTER
NEW YORK

Advertisement appearing in *The Journal of the Florida Medical Association*, 1918.

Seventy-nine developed pneumonia (5.4% of the flu cases) and two of these were characterized: "Unresolved pneumonia confirmed by X-ray." The authors make the point that in almost all instances the pneumonia was bilateral and a bronchopneumonia rather than a lobar pneumonia. Other complications encountered included: empyema, nephritis, otitis, laryngitis, sinusitis, "infectious psychosis," acute thyroiditis, phlebitis, acute cholecystitis and corneal ulcer.

The naval hospital at that time had 237 beds and during the epidemic at one time handled as many as 386 patients. Many of the overflow were in tents set up on the hospital grounds and temporary hospitals were opened in two bungalows and one officers' quarters. In addition 30 beds were available at the dispensary. To care for the sick there were 24 doctors, 14 nurses, and 120 hospital corpsmen. Many of these personnel had uncomplicated influenza and one had bronchopneumonia; none died.

The Microbiology of the Spanish Influenza

Dr. Paul A. Lewis, director of the laboratories of the Phipps Institute of Philadelphia, announced he had isolated the cause of the Spanish influenza on September 21, 1918, the Pfeiffer's bacillus (now known as *Hemophilus influenza*). Friedrich Johann Pfeiffer working in Berlin during a flu epidemic in the spring of 1890 saw this bacillus for the first time. During the succeeding year

he worked with the organism and felt he had proven each of Koch's four postulates and demonstrated beyond doubt that it was the cause of influenza. Thus in 1918 when this organism was isolated from the sputum and lungs of patients with the Spanish flu the leading bacteriologists of the day felt confident that Lewis was correct. However, as the epidemic wore on studies showed that in some cases the Pfeiffer bacillus was not present but instead, streptococcus, staphylococcus, or pneumococcus was found, and in some cases only the normal bacterial flora was present. These findings shook the confidence in the Pfeiffer bacillus as the cause of influenza but it was not until 1933 that the filterable virus concept was proven by Smith, Andrews and Laidlaw working in England.

In Florida the only bacteriological and other laboratory studies I have knowledge of were done at Camp Johnston and at the Naval Air Station in Pensacola. Captain Richard E. Stifel, the physician in charge of the laboratory service of the Base Hospital at Camp Johnston, reported to the Camp Surgeon that in 150 cases studied, characteristically there was a polymorphonuclear leucopenia with total white blood counts as low as 2,000 cells per cmm. On nasal cultures of 145 cases, provisionally diagnosed as the flu, 58% grew out the "influenza bacillus" on rabbit blood agar plates. In some instances he was able to stain the bacillus in the

nasal secretions but they would not grow on culture media. Of 20 sputa examined, 15 cultured the influenza bacillus. In several pneumonia cases either the influenza bacillus or a Type IV pneumococcus was found.²⁵ In his final report²⁰ mention is made of culturing the influenza bacillus from the lungs postmortem but no other details of autopsy studies are given.

At the Naval Air Station, Pensacola,⁵ the sputa of 120 patients were cultured, and 28 of 66 uncomplicated cases of influenza showed the influenza bacillus. Of 54 cases complicated by pneumonia, 33 cultured the influenza bacillus. From these sputa they also cultured *M. catarrhalis*, pneumococcus, streptococcus and staphylococcus. Indeed, the pneumococcus was more commonly grown from the sputa of both uncomplicated influenza cases and pneumonia cases. These investigators also commented on the leucopenia observed and used this as support for their belief that the influenza bacillus was indeed the cause of the flu for the other bacteria they cultured would, they reasoned, have produced a leucocytosis. Finally, in five cases they isolated the influenza bacillus by subcultures on blood agar, emulsified these in normal saline and showed that these bacilli were agglutinated by the serum of the convalescent pneumonia patients. Similar results were also obtained in patients with uncomplicated influenza.

Clinical Aspects and Therapy

The Spanish flu of 1918 was primarily a respiratory illness and but few patients showed gastrointestinal symptoms. The newspaper writers of the day repeatedly emphasize the frightening speed of onset. More than one case is recorded in which progression from the initial symptoms to death occurred in little more than twenty-four hours.

The most detailed clinical description of the flu in Florida appears in the report from the Naval Air Station at Pensacola.⁵ A study of 600 cases there indicated the most usual onset was sudden fever, headache, muscular and joint aches, burning of the eyes, severe lumbar backache and great prostration. In over half the cases the temperature reached 102° to 104°, and lasted about three days. The usual length of illness in uncomplicated cases was three to six days. A mild sore throat was often present and almost all cases developed a severe cough which was worse at night. Because of the severe prostration bed rest was unavoidable for at least a part of the illness. The common treatment at the Naval Air Station Hospital was calomel grains V followed by magnesium sulfate on admission. Other therapies used in uncomplicated cases were: Dover's powder (ipecac, powdered opium and either potassium sulfate or lactose), sodium salicylate, sodium bromide, aspirin, phenacetin, salol (phenyl salicylate) and quinine. The

investigators concluded they got their best results with the initial purge followed by the judicious use of aspirin and Dover's powder.

If the patient developed pneumonia, creosote (one drop on crushed ice every four hours) seemed of benefit. They also recommended a half ounce of whiskey well diluted in water every four hours, if the pulse is weak. Tincture of digitalis thirty drops every four hours orally or 10-15 minims hypodermically was also good if the pulse became weak. Codeine was used as hypnotic and atropine hypodermically helped reduce the chest secretions. In two instances with cardiac embarrassment the patients were bled 180 to 200 cc with apparent benefit. Oxygen by inhalation seemed to help in desperate cases and in two cases in which the cyanosis was not relieved by oxygen inhalation, oxygen was injected subcutaneously into the abdominal and chest walls. It was thought the oxygen would be picked up by the blood from this reservoir. Other time-honored measures widely used were ice caps, tepid sponging and mustard plasters.

At the Naval Air Station the patients who developed pneumonia were kept in bed for seven days after they became afebrile then ambulation was started gradually. For convalescence a nutritious diet, plenty of rest and fresh air was recommended. The City Health Officer in Jacksonville also recommended an elixir of iron, quinine, arsenic and strychnine, one teaspoonful three times daily for adults.

Community-Wide Measures

In the smaller cities and towns the people faced with this overwhelming catastrophe depended upon a neighbor help neighbor system. In the metropolitan areas such as Jacksonville, Tampa and Pensacola this would not suffice for there were many newcomers who had no friends to rely upon and many who were living on the fringe of poverty with no means to help themselves when the breadwinner was struck down or the place of employment closed. In Jacksonville and Pensacola public relief committees were organized, sometimes under the auspices of the American Red Cross. These committees established a headquarters to which the needy could appeal, a communications network and subcommittees to do the work of relief. In Tampa the city board of health organized the relief efforts with the Red Cross and many volunteers assisting.

Early in the epidemic it was evident that whole families were too sick to feed themselves and soup kitchens were established. In Jacksonville the first soup kitchen was established by the Sunday school of the Union Congregational Church. Citizens, black or white, were asked to come with containers and pick up the quantities needed for themselves and their neighbors. If

no one was available to come for the soup a telephone call would obtain delivery. On the first day over 100 families were supplied with soup. The following day Schemer's Restaurant offered free soup to all who called for it and the soup kitchen began distributing soup in waxed paper containers that were to be burned after use. On October 13th, General W. P. Duvall, Commandant of Camp Johnston, made available to the city four portable soup kitchens, three trucks and two officers with fourteen men to operate these. These were dispersed throughout the city and on that date 700 whites and 600 blacks were supplied with soup. The recipe for the soup is described thus: "Rich soups were made from meats and vegetables and then strained to separate the solid foods. The latter were given to colored charitable organizations and were found to make excellent hash."²⁶ The charitable act by General Duvall received nationwide publicity and soon many other cities throughout the country demanded equal participation from the army. The publicity was promptly terminated as the many demands could not be met.

In Tampa the Red Cross under the energetic Mrs. T. L. Kern, began distributing broth at the Wolf Mission on October 16th, and soon thereafter soup kitchens were opened in Ybor City, West Tampa and Ellinger City. A diet kitchen was opened in the Robert's Cigar Factory and Mr. George Mason, proprietor of the Mason Hotel offered free soup to all who would come for it. Still later a soup kitchen for blacks was opened in the Mugge Building on Central Avenue. The formula for soup in Tampa had a Latin flavor: beef broth, macaroni,

vermicelli and tomatoes.²⁷ On October 31st, as the epidemic began to wind down, the paper announced there was an excess of soup in the soup kitchens.

In Pensacola the Relief Committee began distributing soup about October 9th. In addition it distributed milk, buttermilk, ice, eggs, and groceries. On October 13th, the Relief Committee reported it had dispensed thirty gallons of milk and ten gallons of soup the previous day. The committee also distributed medicines. With the subsiding of the epidemic these distributions were ceased on October 14th.

In each of the metropolitan areas there were repeated appeals in the newspapers for volunteers to make gauze masks, to collect bedding and night clothes for the needy, to deliver food and medicines, and most of all to nurse the sick. In Tampa a public-spirited automobile dealer, M. J. Hulsey, started an influenza fund to which many citizens contributed and which was used to help needy families during the period when the breadwinner could not work. A similar fund was established in Jacksonville.

Preventive Measures — Public and Private

Perhaps the single most widely applied preventive measure was a ban on public gatherings. On October 8th, the Surgeon General of the United States wired all state health officers strongly advising that schools and other places of public congregation such as movie theaters, pool rooms, dance halls and churches be closed. Streetcar conductors were ordered not to let

In the treatment of **INFLUENZA**

especially when complicated by bronchitis, clinical experience in the present epidemic has shown that the administration of Calcreose has been followed by results fully comparable with those obtained from the use of this new creosote product in other inflammations of the lung and in gastro-intestinal infections.

Write for "Calcreose" Booklet.

The Maltbie Chemical Co., Newark, N. J.

Advertisement appearing in
*The Journal of the Florida
Medical Association*, 1918.



CALCREOSE

aboard more people than could be seated. Retail stores were to be open only from nine in the morning until four in the afternoon so that shoppers would not compete with workers for the streetcar seats. Citizens were asked to have funerals limited to the immediate family so as to reduce the size of the gathering. In the larger cities church services were voluntarily suspended for the duration of the epidemic and the ministers had their hands full caring for those of the flock who were sick.

The wearing of gauze masks, at times saturated with a disinfectant solution, was popular in some areas, particularly in Tampa. Although elsewhere in the United States city ordinances requiring the wearing of masks were enforced by the police, in Florida it seems to have been enforced only by public disapproval of the non-wearers. A possible exception was Tampa where the city board of health decreed that all barbers wear masks sprinkled with Dobell's Solution (sodium borate, bicarbonate of soda, carbolic acid and glycerine). At one point in Tampa it was suggested that cigar makers be required to wear masks at work; this would prevent them coughing on the tobacco leaves but most importantly it would keep them from moistening the leaves with their saliva to make them shape properly as they rolled the cigar. This suggestion met with instant rejection by the cigar makers and was never instituted.

Only in Tampa was placarding of houses of the sick carried out. Bubber Harris, the government advertising agent for the Tampa area was assigned the task of nailing

on the front doors of houses containing the sick a card in both English and Spanish reading: "There is influenza in this house. No visitors are allowed."²⁸ Bubber wanted the citizenry to know that he would be wearing a mask for his own protection and urged them not to mistake him for a marauder.

In all areas of the state citizens were admonished not to cough and spit in public but only in Tampa was this ruling enforced. Spitting on the sidewalk in Tampa would get you arrested and fined one dollar. The members of the local Rotary Club were "deputized to stamp out this filthy habit." Apparently several persons were arrested for sidewalk spitting in the downtown area. On October 20th, the following news item appeared in the *Tampa Sunday Tribune*: "Fire apparatus was drafted into the battle yesterday and during the day the chemical engine drove up and down Franklin Street sprinkling disinfecting solution in front of the downtown stores . . ." For the disinfection of houses it was recommended that a mixture of one-third turpentine and two-thirds water be boiled and the steam allowed to permeate the house.

Finally, on October 22nd, a delegation of Latins from Ybor City appealed to the city fathers for permission to burn tar at the street intersections to drive away the evil miasmas. They pointed out that this was a time-honored custom during epidemics in Latin countries and that, "the moral influence could not but be good."²⁷ The reader is reminded that this custom comes down to us from the middle ages and was the cause of the great fire in London

Chlorazene

USE IT AS A PROPHYLACTIC AGAINST SPANISH INFLUENZA

McCord, Friedlander and Walker, of Camp Sherman, in the July 27th issue of the A. M. A. Journal, report remarkable results with gargles of CHLORAZENE, followed by Dichloramine-T sprays in the treatment of diphtheria patients and diphtheria carriers.

Capt. Paul G. Woolley, of Camp Greene, in the Journal of Laboratory and Clinical Medicine for April, says: "In the only organization which made use of systematic nasal sprays since the first of the year not a single case (of meningitis) developed. * * * One comes to have a very healthy respect for Dichloramine-T as an agent for the prevention of diseases of upper respiratory tract ori_in."

GARGLE WITH CHLORAZENE—SPRAY WITH DICHLORAMINE-T

CHLORAZENE and DICHLORAMINE-T should be used promptly to check the spread of infection wherever SPANISH INFLUENZA threatens to become epidemic.

Order today. Literature upon request.

CHLORAZENE, tablets or powder.
DICHLORAMINE-T, in one-ounce bottles.
CHLORCOSANE, four ounces or more.
Atomizer, especially adapted for
Dichloramine-T solutions, \$1.50.

THE ABBOTT LABORATORIES
Home Office and Laboratories, Chicago, Dept. 32

New York Seattle San Francisco
Los Angeles Toronto Bombay

Advertisement appearing in
*The Journal of the Florida
Medical Association, 1918.*

during the bubonic plague of 1666.

At a personal level citizens had confidence in various things to prevent the flu. Thus the manager of the Tampa Electric Company who escaped illness attributed his good fortune to "a little sack of camphor" which he carried everywhere. There must have been those who credited the asafetida or horse chestnut worn around the neck or some talisman carried in their pocket. The patent remedy people enjoyed a boom as they peddled their products to sterilize the nose (Vicks Vaporub) or tone up the system (Grove's Tasteless Chill Tonic). So popular was the Vicks Vaporub that the company advertised in *The Florida Metropolis* on October 28th, their stocks were severely depleted and they could not keep up with the demand. During the previous week they stated they had sold 1,250,000 jars.

At the military bases where rigid control was possible the preventive and public health measures were perhaps more rational and certainly more uniformly applied. Early in the epidemic the armed forces personnel were restricted to their bases either at the initiative of the camp commander or, as in the case of Pensacola, at the request of civil authorities. The only detailed account of the measures taken comes from Camp Johnston. In his report on the epidemic, Camp Surgeon, J. Y. Porter, tells us that a quarantine of the camp was in force from October 14th to October 24th. Within the camp all but the most necessary assemblies were avoided. All newcomers to the camp were examined on arrival and were held in the receiving group fourteen days and all personnel were examined daily throughout the epidemic. All dishes, kitchen ware and even the soldiers mess kits were sterilized in an electric dishwasher after each use. The floors of the barracks and tents were oiled to keep down dust. "Beginning October 8, 1918, all White and Colored Troops in the Receiving Group were treated to Nasal-Pharyngeal applications of 1½% Protargol Solution. Glass medicine droppers were used in the administration."²⁰ These applications were done twice daily and Porter presents statistics indicating a marked reduction of new cases during the succeeding six days.

All recognized cases of influenza were transferred to the Base Hospital where they were placed in screened cubicles allowing 800 to 1000 square feet of floor space per man (sic). Thirty-five hospital tents with flooring and screens were erected on the hospital grounds to be used for the convalescent cases. The severe cases of influenza and all pneumonia cases were cared for in the hospital. The pneumonia cases were kept in separate wards or on the porches despite the rainy weather that was then prevailing. All hospital and infirmary attendants and the patients wore gauze masks covering the mouth and nose.

Both an influenza vaccine and a pneumonia vaccine

were tried on small groups of the men. The "Influenza bactrin mixed (Mulford)" which contained killed hemophilus, staphylococcus, streptococcus, pneumococcus, Friedlander's Bacillus and M. catarrhalis organisms, was given every 48 hours for three injections. Of 1730 men so treated only 19 developed influenza and none developed pneumonia. It must be noted that this vaccine was first administered on October 14th, considerably after admissions to the base hospital had peaked (October 8th) which suggests that the epidemic was already subsiding. Porter's report states that none of those injected with at least two bactrin injections developed influenza but at another point he recounts that he developed influenza after three of these injections; and he was sure the injections mitigated the disease.

On October 13th, 1100 men were vaccinated with a Pneumococcus Lipovaccine containing 10,000 million killed organisms of each of Types I, II and III pneumococci. No report is given of its effectiveness but of the few pneumonia cases in which the sputum was cultured, the organisms obtained were either Hemophilus influenza or the pneumococcus Type IV. Neither of these organisms would have been affected by the vaccine that was used. Vaccines of various sorts were used throughout the United States and the final conclusion reached by epidemiologists months later was that no beneficial effect could be shown from any of them.

In mid-December 1918, the American Public Health Association held a meeting in Chicago to review the information gathered on the Spanish influenza and make suggestions for future such epidemics. There was agreement that the disease was spread by mouth and nasal discharges and that isolation of all cases is imperative. People in direct contact with patients or possible patients, such as medical and nursing personnel, barbers and dentists should wear masks but there was no evidence that masking the entire population was of value. Early closing of public gatherings during an epidemic was of value and laws regulating coughing and spitting were desirable. Rest and good hygiene seemed to help and care of patients at home was preferable to hospitalization. Sprays, gargles and vaccines were of equivocal value.²⁹

The Epilogue

The Spanish flu epidemic of 1918 gradually abated in November but was probably not dead, just dormant. In January and February of 1919 it recurred throughout the United States including north and west Florida. In Jacksonville and Duval county there were 784 cases with possibly as many as 218 deaths reported.³⁰ Again in January and February 1920, an influenza with all the earmarks of the Spanish flu appeared throughout the United States and again it was present in North Florida.

Deaths From Spanish Influenza/Pneumonia

Apalachicola	10	Miami	66
Arcadia	6	Ocala	11
Bartow	1	Orlando	6
Bradenton	4	Palatka	14
Daytona	4	Pensacola	87
Deland	11	Plant City	10
Fernandina	5	Quincy	20
Fort Meyers	6	St. Augustine	14
Gainesville	21	St. Petersburg	6
Jacksonville	398	Sanford	3
Key West	64	Tallahassee	7
Kissimmee	4	Tampa	225
Lake City	11	West Palm Bch.	7
Lakeland	6	West Tampa	1

In Duval County, 2881 cases were reported with 243 deaths.³⁰

In the subsequent years the field of virology has developed with the brilliant work of the American, Richard E. Shope, and the British trio, Wilson Smith, C. H. Andrewes and P. P. Laidlaw and many others. The British trio first proved influenza was caused by a filterable virus while working with an outbreak in 1933. Shope had previously proven swine influenza due to a filterable virus but he thought Pfeiffer's bacillus had to be present also. Studies have shown immunologic similarities between the Shope virus and the virus isolated by the British group. There is also suggestive evidence that the Shope virus is immunologically similar to the virus of the Spanish flu. Recently it has been shown that people who survived a pandemic of flu in 1889-1890 which began in Russia had antibodies to the Asian flu of 1957 before that pandemic arose.

In summary, there are findings that strongly suggest the human race can reasonably expect the cyclic return of pandemic influenza. This is the rationale behind the annual administration of influenza vaccines in this country. These vaccines are designed by the epidemiologists and virologists of the United States to contain the most virulent strains of influenza virus that have appeared in the world during the preceeding year. It is hoped that by giving these vaccines to a large segment of the people another Spanish flu catastrophe can be avoided.

References and Footnotes

1. "More Volunteer Nurses Needed to Handle Influenza Cases in Tampa," *The Tampa Morning Tribune*, Oct. 23, 1918, p. 5.
2. Martin, Richard A.: A Century of Service. St. Luke's Hospital, 1873-1973, Jacksonville, privately printed, 1973, pp. 164-165.
3. Crosby, Alfred W., Jr.: Epidemic and Peace, 1918, Westport, Conn., Greenwood Press, 1976, pp. 18-19.
4. Crosby: p. 205.
5. Perret, J. M. and Shaar, C. M.: Study of an Epidemic of Influenza at Pensacola, U. S. Naval Medical Bulletin 13: 365-378, (April) 1919.
6. "Spanish Grippe Finds Its Way Into the South," *The Florida Metropolis* (Jacksonville), Sept. 19, 1918, Sect. #1, p. 8.
7. Thompson, Stewart G.: Report of the Central Bureau of Vital Statistics, Part I, 1918 Influenza, Thirtieth Annual Report of the State Board of Health of Florida, 1918, Jacksonville Printing Co., p. 173.
8. "Influenza Among American Indians," Treasury Department Public Health Reports 34: (19), May 9, 1919, pp. 1008-1009.
9. Davis, T. F.: History of Jacksonville, Florida and Vicinity, 1513 to 1924, Gainesville, University of Florida Press, Floridaiana Facsimile & Reprint Series, 1964, p. 274.
10. Letter: Porter, J. Y. to Commanding Officer, Sept. 19, 1918, R. G. 112, Records of the Surgeon General's Office, World War I Organization Records, Medical Department, Camp Joseph E. Johnston, Florida. National Archives and Records Service, Washington, D.C. Hereinafter such records will be designated: "R. G. 112, Records of the Surgeon General's Office, WWI."
11. Davis: p. 273.
12. "Dover Has Fatal Case of Spanish Influenza," *Tampa Morning Tribune*, Sept. 29, 1918, p. A-9.
13. "Restrictions At Tampa Lifted By Board," *The Florida Metropolis* (Jacksonville), Nov. 4, 1918, p. 3.
14. "Move to Stop Influenza In Epidemic Here," *The Pensacola Journal*, Sept. 29, 1918, p. 1.
15. Vickers, E. D. and Vickers, F. N.: Notations on Pensacola's Medical History 1873-1923, JFMA 61: 83-105, Jan. 1974.
16. "Call For More Relief Nurses," *The Pensacola Journal*, Oct. 8, 1918, p. 1.
17. "City Physician Favors Closing Public Dances," *The Pensacola Journal*, Dec. 15, 1918, p. 17.
18. May, Judge E. C.: 'Gators, 'Skeeters and Malaria, New York, Vantage Press, Inc., 1953, p. 154.
19. "Quincy Is Grippled By Influenza, 1000 Cases Reported," *The Pensacola Journal*, Oct. 13, 1918, p. 2.
20. Report of Epidemic Influenza at Camp Joseph E. Johnston, Camp Surgeon to the Surgeon General, U.S. Army, Washington, D.C., December 18th, 1918, R.G. 112, Records of the Surgeon General's Office, WWI.
21. Another report sets this figure at 4,145 but Surgeon Porter apparently felt this higher figure incorrect.
22. X-ray equipment must have been in use at Camp Johnston for it was definitely in use at the Naval Air Station Hospital in Pensacola and in the larger cities and towns of Florida but there is no mention of chest x-rays used for diagnosing the pneumonia.
23. Crosby: pp. 228-229.
24. Crosby: p. 46.
25. Stifel, Richard E. to Porter, J. Y.: Laboratory Investigation of the Influenza, Sept. 30, 1918, R. G. 112, Records of the Surgeon General's Office, WWI.
26. "At City Health Office Affairs Become Normal," *The Florida Metropolis* (Jacksonville), Oct. 25, 1918, p. 12.
27. "Epidemic Working Toward Peak: 22 Deaths and 1,022 New Cases," *The Tampa Morning Tribune*, Oct. 22, 1918, p. 5.
28. "Efficient Work Being Done in Stamping Out Dread Influenza," *The Tampa Morning Tribune*, Oct. 17, 1918, p. 5.
29. "Recommendations of a Meeting of the American Public Health Association on Influenza Held in Chicago, December 9-12, 1918," Florida Health Notes XIII, Feb. 1919.
30. Martin: p. 186, fn. 46.
31. "Report From SBH: Oct. 5 — Oct. 27, 1918," *The Florida Metropolis* (Jacksonville), Oct. 29, 1918, p. 12.

• Dr. Straight, 550 Brickell Avenue, Suite 212, Miami 33131.



SPECIAL ARTICLES

Excellence in Medicine: A Rewarding Pursuit

Michael E. DeBakey, M.D.

More than two centuries ago, Samuel Johnson advocated perfection as a reasonable quest, even though we can only pursue, but never attain it. Once the fervent exhortation of parents, teachers, and national leaders, the pursuit of excellence — along with God, mother, and country — fell into curious disfavor in the sixties and seventies. Reason, self-discipline, and the work ethic were scorned, and we were urged to “do our own thing,” “let it all hang out,” and “get in touch with” or “self-actualize” ourselves, whatever those phrases mean. With little fuel to sustain it, the lamp of excellence flickered weakly.

The question I wish to address today is: *Can we, and should we, rekindle the lamp of excellence?* I stand on the affirmative side, for I consider the pursuit of excellence a worthy and rewarding one, particularly in medicine, and probably most important in that noble profession you have chosen for your life's work.

Were it not for the dedication to excellence of our forebears, we would not enjoy the comforts and luxuries that we now consider necessities. By industry, ingenuity, and perseverance, they converted Nature's resources to the service of humanity. To facilitate travel and commerce, ingenious human minds devised trains, steamboats, automobiles, airplanes, and even spacecraft. To expand communication, they invented the radio, telephone, Teletype, and television. To foster health and prolong life, they instituted sanitation, developed preventive vaccines and curative drugs, and devised remarkable surgical procedures. And to satisfy the aesthe-

tic sense, they created exquisite art, literature, and music. All these feats issued from people who stretched their abilities to the limits, but at the same time achieved that highly important, if not *the* most important, element of life — gratification.

Excellence, however, is not the exclusive province of the wisest, the strongest, or the purest; it can be attained in modest as well as Icarian endeavors. A master cabinetmaker can produce a work of art as beautiful as a fine painting or a well-reasoned theorem, and we need cabinetmakers just as we do artists and logicians. No matter, therefore, the nature of the product; it is the *quality* of the performance that counts. In the words of Sir William Osler: “The artistic sense of perfection in work is [a] much-to-be-desired quality to be cultivated. No matter how trifling the matter on hand, do it with a feeling that it demands the best that is in you, and when done look it over with a critical eye, not sparing a strict judgment of yourself.” The discovery of an exciting new scientific concept; the creation of a flawless painting, immortal poem, or majestic symphony; the development of a successful treatment for a disabling or fatal disease — or the repair of a malfunctioning motor — all impart a deep satisfaction. No matter how lofty or lowly the labor or how magnificent or menial the product, the reach for excellence carries excitement and gratification.

You, the 1981 graduating class of the University of Florida College of Medicine, have a special opportunity, and I believe a responsibility, to pursue excellence. You received your education at a prestigious institution of higher learning, which has zealously nurtured this pursuit, and you chose a career in which you will be dealing with human health and lives — the most precious of earth's resources. Mediocrity, although tacitly countenanced in many aspects of life today, has absolutely no place in medicine.

Excellence in medicine is not confined to diagnostic

The Author

MICHAEL E. DeBAKEY, M.D.

Dr. DeBakey is Chancellor, Baylor College of Medicine, Houston, Texas. This address was delivered by Dr. DeBakey at Commencement, University of Florida College of Medicine, Gainesville, May 30, 1981.

and therapeutic techniques. It also entails an understanding of, and attention to, the concerns, apprehensions, fears, uncertainties, anxieties, and feelings of helplessness induced by illness. It means listening attentively and compassionately to the patient, allaying those concerns and anxieties, and explaining in simple, comprehensible language what the symptoms mean, how they can be treated, and what can be expected as a result. A gentle touch of the hand has a remarkably salutary effect on patients. Remember, too, that when you accept a patient, you enter a partnership, each member of which must do his share to make the treatment work. The patient also needs to understand what you *cannot* do for him. Much of the disenchantment with physicians — a highly popular and, I might say, exaggerated topic with journalists today — derives from overexpectations on the part of patients. You can correct that problem by advising the patient of the limitations of medicine. Some need to be disabused of the idea that you can prescribe a magic pill that will allow them to continue their unhealthy lifestyles without adverse effects. Effective communication is crucial between physician and patient, and communication is a two-way process. The patient's cooperation in his treatment is important, and he can cooperate fully only if he understands thoroughly what he needs to do to comply with your plan of management.

You have had the advantage of a special kind of education — one that prepares you for a particularly fulfilling career. But all education, by definition, implies a pursuit of excellence. The fate of a democratic society lies in the social, political, economic, and moral decisions made by its individual members, and wise decisions derive from an informed mind. Creative thinking simply does not flow from an empty head. Since each citizen in a democracy is expected to participate in judgments that affect the general public, the education of individual members is a legitimate concern of all others. When education is neglected or compromised, ignorance, fear, and prejudice — freedom's worst enemies — flourish. Not that we all need or should have the same *kind* of education, but each person in a democracy should have the *opportunity* to pursue his vocational choice and to fulfill his potential in life.

Those who contend that high standards of education are undemocratic have little understanding of democracy. Excellence and justice, rather than being discordant, are highly compatible. Democracy does not, however, demand embracing minimum standards or the least common denominator; it works best, in fact, in a highly developed intellectual, moral, and cultural milieu. The reach for intellectual excellence, by sharpening our critical faculties and expanding our understanding, allows us to evaluate public issues intelligently and to make fair, judicious personal, social, and political decisions. It pre-

vents entrapment of the mind by arguments that are superficially enticing or intimidating, and it holds the key to our future. The acceptance of mediocrity, on the other hand, is demeaning and detrimental to everyone.

The freedom that we cherish so deeply is not license to do, or not do, as we please; it entails accountability for our words and our deeds. The more personal responsibility we exercise, the less government intervention we need. Conversely, the more our government dictates or controls, the less initiative, judgment, and responsibility are left to us. One index of the increasing federal intervention in our lives is the expansion of rules and regulations by the federal regulatory agencies. Each year Americans spend 785 million hours filling out 4,987 different federal forms. According to the Commission on Federal Paperwork, processing and filing federal forms cost about 100 billion dollars annually!

The deep intrusion of government into the affairs of our schools has resulted in substantial and costly expansion of administrative activities. Funds so expended are, of course, diverted from purely educational purposes. Some governmental regulations, for example, are totally outside the three traditional functions of medical schools — education, research, and patient care. The attendant paper work and record-keeping are overwhelming. Let us hope that government intervention will abate.

We have read and heard a great deal of late about "spiraling health costs." Inadequate emphasis has been placed, however, on the direct responsibility of the government for much of the increase. A recent study by the Hospital Association of New York State showed that meeting governmental regulatory requirements of 164 agencies accounted for one-fourth of all hospital costs in that state (\$1.1 billion per year). Even the government's attempts at "cost containment" have driven costs up by eroding the financial base of hospitals and further distending a profligate bureaucracy — without any proved benefit.

While the attack on the high cost of health care has been loud and unrelenting, we have heard few complaints about the high cost of entertainment — or the millions that "superstars" receive for a single performance. Should we conclude that our society values entertainment above personal health? In a recent magazine poll of several hundred students from fifth grade through high school, eight of the 10 "heroes and heroines" selected by the girls and seven of the 10 selected by the boys were entertainers or athletes. Conspicuously absent were any writers, artists, composers, scientists, jurists, theologians, educators, or others who have traditionally made enduring contributions to society. The question is: Can our society maintain its international primacy if it values fleeting entertainment above lasting cultural and intellectual achievements?

As responsible American citizens, we have an obligation to preserve freedom of thought, expression, and movement — freedoms that subsume responsibility. Condoning aimlessness, underachievement, and antisocial behavior by relieving the individual of all culpability and shifting responsibility to society is dangerous. As Aristotle observed centuries ago, moral virtue is acquired not primarily through schooling but through home training; it is repeated acts of justice and self-discipline that instill decent behavior and noble human values. Moral and cultural development are as important as the cultivation of intellectual virtues. Man is not merely a mechanical apparatus; he has an imagination, an aesthetic sense, and a conscience, all of which require nourishment. Art, literature, and music enrich human life, and moral and ethical convictions invest it with special meaning. Those moral and ethical convictions include a respect for the highest human values — honesty, compassion, justice, liberty, and brotherhood. Nor is it enough simply to mouth these abstract terms; we need to practice them in our daily living.

Coupled with a clear sense of purpose and direction, these social ideals can lead to a full, happy, productive life. Physicians, more than most others, have an opportunity to practice these ideals — in their daily work and in their daily lives. As you enter the noble profession of medicine, I urge you to consider these opportunities. While pursuing your scientific and intellectual curiosity,

you can simultaneously satisfy your humanitarian instincts and your social and civic responsibilities. I promise you they will lead to inner contentment and fulfillment. Life has few greater satisfactions than seeing a patient previously incapacitated by illness, perhaps even bedridden, become restored, under your careful ministrations, to a healthy, zestful, productive life. The positive changes in the faces and lives of the patient's family are equally heartwarming.

In an era when our natural resources are dissipating, when nuclear weapons are proliferating, when literacy is declining, when the moral climate is degenerating, and when social, economic, and political crises are accelerating, our very survival may depend on our willingness to exert the extra effort needed to reverse these trends. For those willing to make the commitment, the quest for excellence will more than compensate you for your efforts. We must, however, not only set our sights high but must develop endurance and patience, for, as Voltaire noted, "Perfection is attained by slow degrees; it requires the hand of time." Let me close with this memorable passage from Hesiod: "Before the gates of excellence the high gods have placed sweat; long in the road thereto and rough and steep at first; but when the heights are reached, then there is ease, though grievously hard in the winning." May each of you reach those heights, and may you win the ease and the pleasure that accompany that achievement.

Bad Hospital PR — The Patient Pays

F. Norman Vickers, M.D.

This editorial, written at the suggestion of ECMS Executive Committee, is a plea for hospital cooperation. In recent years, the Pensacola community has observed an increasing spirit of competitiveness among hospitals. We are not talking about the kind of competitiveness which makes for better patient care with increased service to the patient at lower cost. We are talking about increasing competition for the patient and the patient

dollars.

The recent controversy about the designation of a regional trauma center by the Florida Panhandle Regional Emergency Medical Services Management Organization, Inc. (REMSMO) has accentuated the undesirable kind of competitiveness. At the time this editorial is written, REMSMO has not made that designation. According to the legal regulations, only one hospital will have the "official" designation as regional trauma center. It is not the intention of this editorial to review the ramifications of this. Suffice it to say that the Medical Society feels that any or all of the three hospitals — Baptist, Sacred Heart, West Florida — are capable of meeting these criteria. As a part of this controversy, there was a flurry of activity in renaming hospital emergency rooms to emergency/trauma centers. There was the construction of new signs

The Author

F. NORMAN VICKERS, M.D.

Dr. Vickers, a gastroenterologist practicing in Pensacola, is editor of the Escambia County Medical Society Bulletin in which this article originally appeared. Dr. Vickers is also Book Review Editor of The Journal.

to alert the passing public and attract potential emergency/trauma victims. Then there was the accompanying newspaper and broadcast publicity regarding the renaming, conversion of these new trauma centers and the hospital expenditures to meet these criteria.

Another kind of undesirable competitiveness we are talking about is the striving for newspaper and broadcast "publicity" regarding new facilities. The implication in some of these news releases, at least from our point of view, is that each hospital plays up their newest equipment, implying that this gives them the edge in treatment in some way. One news story implied that a certain hospital had a monopoly on compassion for fat patients! The position of the Medical Society has been that it is certainly right and proper that new advances in the community should be publicized. We have also held that emphasis on service to the patient and the community should be foremost. A balanced news release would emphasize comparable facilities at other hospitals in the community. We note in recent years that this emphasis on similar facilities in the community has been conspicuously absent. We call on our colleagues, not only in hospital administration and in hospital PR, but in the print and broadcast media to help provide that "balance" for the community and reader by checking with the other hospitals or the ECMS Public Affairs Committee to determine if comparable services are available here. This we regard as a duty incumbent on both hospital and the news media representatives.

Now a word about hospital advertising. In the past, there seemed to be a spirit of friendly cooperation. For example, in past years during National Hospital Week, an inter-hospital newspaper supplement was prepared for the public which emphasized the services provided by area hospitals. In the last year or so, hospitals have published their own Sunday supplements, first, West Florida, then, Sacred Heart, and most recently, Baptist.

Now you are more or less even! Why not get together and cooperate once again? We respectfully suggest a moratorium on individual hospital Sunday Supplements and paid hospital advertising.

Why not plan for a combined supplement next year during National Hospital Week emphasizing service to the community? Each hospital would have an opportunity to emphasize their unique contribution to the health of the community. We feel that this would be in much better taste and benefit.

Now another word about hospital advertising. It is distasteful to us to see the insidious growth of this. When the hospital advertises for nursing and ancillary health personnel over TV, the implication is that they are also advertising for patients. Where will it stop? We note with alarm and distaste in the May 1st issue of *American Medical News* that a hospital in San Francisco went to the airways to increase its outpatient and inpatient load. We deplore that and hope it will not become commonplace. It also doesn't make much sense in this area since the private hospital bed census is at a comfortable, and profitable high level.

The Medical Society recently wrote the Interhospital Council for an update on their policy regarding news releases, advertising and public relations effort. To date, we have had no official reply from that body. Hospital administrators, we hope you are talking cooperatively with each other.

One final word about paid hospital advertising. Whenever you see the paid ad in the newspaper or on radio or TV, you should remember that the money for that ad came from a patient's pocket, directly or indirectly. This is the only revenue of hospitals. We suggest that this editorial be posted in physician waiting rooms, emergency trauma centers and on the bulletin board of your hospital administrator.

Hospital Privileges: Who Should Have Them?

R. G. Lacsamana, M.D.

The story sounds familiar, but let us rehash the scene:

The Author

R. G. LACSAMANA, M.D.

*Dr. Lacsamana is an internist practicing in Daytona Beach. This editorial originally appeared in the June 1981 issue of **The Stethoscope**, the Medical Bulletin of the Volusia County Medical Society, of which Dr. Lacsamana is editor. He is also a consulting editor of **The Journal**.*

Dr. J. R. Shrinkhead is a new physician in town and he applies for hospital privileges at the Super-A Medical Center. The Credentials Committee reviews his files, interviews him, and finds him unqualified. He disagrees with the decision, and he has three alternatives open to him: he can forget about the whole thing and quietly leave town, he can appeal his case or, failing in his appeal, he can sue the hospital as a last resort.

There are many variations to this story but it serves

to illustrate the dilemmas that hospital staffs across the country may increasingly face in the future. With a bigger number of new physicians going into practice each year and with the militant advances by non-M.D. practitioners seeking entry into traditionally M.D.-run institutions, the problems are likely to get compounded. The ugly hand of politics, with its penchant for seeking simplistic solutions for complex problems, only serves to cast another dark shadow over the landscape.

Hospital privileges, for most physicians, are an absolute necessity. They provide practitioners not only a place to confine their sick patients but also access to diagnostic and therapeutic facilities not available in an out-patient setting. Moreover, they make it possible for physicians to avail of consultation from various specialists and subspecialists for their hospitalized patients. Clearly, hospital privileges are a *sine qua non* for American physicians in their medical practice.

But who should be given hospital privileges? Should they be given to every physician and practitioner who claims he is qualified to practice medicine? And who should set the guidelines for the medical staffs? Should we allow the continued intrusion of elements like politicians to legislate and dictate to us who we should admit to medical staffs?

The answer to these questions are not easy as they once were in the past. The climate and the passion of the times are changing and it is from this perspective that we should address these questions.

It will help to understand the problem better, and possibly seek a solution, by harking back to one key word: standards. Yes, standards. Hospitals, whether public or private, should enforce minimum standards to protect the patients and to assure good medical care; anything less than this is unacceptable. It is true that standards, to a certain extent, may vary from community to community; it is also true they have changed and evolved over many years, because of changes within Medicine itself. Changes in standards, however, have always been towards a higher plane of quality. Consider this example: Twenty years ago, general practitioners were allowed to do most major surgical procedures; with the advances and specialized techniques that have taken place, only surgeons with appropriate training are allowed to do the same procedures. This is logical and is not deemed to be discriminatory to the general practitioners.

Hospital credentials committees, in enforcing these standards, have drawn up certain guidelines, usually

specifying a required amount of medical training. This is true for both American and foreign medical graduates. FMGs, even from such countries like the United Kingdom and Australia where the quality of medical education is deemed equal to that in the United States, are required to have equivalent training in American hospitals even if they had previous training in their countries of origin. With specified guidelines, it should be easy to sift the good from the marginal, the qualified from the unqualified. Indeed, in most cases, this is the rule. Legal challenges to these standards will be mounted here and there, but reasonable standards will always stand the scrutiny of courts and judges.

The problem begins when other practitioners, with a different educational base but claiming to be qualified, apply for privileges and get rejected. It has happened elsewhere. A chiropractor applied for privileges in a small town in Oregon and got rejected; he sued the hospital and won. Here in our own county, a group of osteopathic physicians sued the Halifax Hospital Medical Center charging discrimination. What about the physician's assistants, the advanced nurse practitioners, the acupuncturists, the holistic practitioners, and the natural healers? Should they be thrown out? In an increasingly consumer-oriented society, where pluralism in medical care is encouraged, it is not far-fetched to expect that these "other" practitioners would be knocking at our doors soon.

It may be argued that credentials committees have a perfect right to reject non-M.D. applicants on the ground of failure to meet required standards. It would be unreasonable, after all, to expect physicians to oversee and supervise the activities of practitioners whose education, training, and standards are not consistent with established standards of the medical profession. Unfortunately, this is not as easy as it sounds.

The search for solutions to the question of hospital privileges may not be easy, given the present political atmosphere and the assorted number of characters seeking entry into what is considered the best system of medical care in the world. In our quest for ultimate remedies, whether these are going to be dispensed by credentials committees, judges, politicians, or consumers, one thing should not be forgotten: Standards which have stood the test of time should never be prostituted, and, just as important, the interest of the patient should always be paramount. That is an obligation where nobody should fail.

NIH Conference to Examine CT Scanning

"Computer Tomography Scanning of the Brain" will be the subject of a consensus development conference sponsored by the National Institutes of Health.

The conference will be held November 4-6, 1981, in Masur Auditorium, in the NIH Clinical Center (Building 10).

The National Institute of Neurological and Communicative Disorders and Stroke is the lead Institute for this conference. Co-sponsor is the National Cancer Institute, in conjunction with the National Center for Health Care Technology. Assistance will be provided by the NIH Office of Medical Applications of Research.

The purpose of the conference is to reach agreement on issues involving computerized tomography (CT) scanning of the brain. Key questions include: What are the indications for employing CT scanning as a primary or secondary diagnostic tool for lesions of the brain? Are there any contraindications? How much radiation is delivered during use of current CT scan equipment, and how is this dosage commonly expressed? Has CT scanning influenced the management of intracranial disorders, such as malignancy, trauma, vascular anomalies, and cerebrovascular disease? Has the availability of CT brain scanning influenced the use of other methods of imaging the brain? What is the practical limit of definition and

resolution in CT scanning that may preclude its value in the diagnosis of brain disease? What can be expected of future efforts in the development of CT scanning beyond its current diagnostic capabilities?

This consensus development conference will bring together biomedical research scientists, radiologists, radiation therapists, neurologists, neurosurgeons, other practicing physicians, consumers, and other persons from relevant fields. On the first two days of the conference, a series of experts will present their experiences and discuss the key issues with panel members responsible for developing a statement of consensus. On the third day, Friday, November 6, the panel, chaired by Fred Plum, M.D., chairman of the Department of Neurology at Cornell University Medical College, will present its preliminary report and invite comments from the audience.

For program information, contact: Dr. Michael D. Walker, Director, Stroke and Trauma Program, National Institute of Neurological and Communicative Disorders and Stroke, Federal Bldg., Room 8A08, 7550 Wisconsin Ave., Bethesda, Maryland 20205, (301) 496-2581.

For administrative information, contact: Mr. Peter Murphy, Prospect Associates, 11325 Seven Locks Rd., Suite 220, Potomac, Maryland 20854, (301) 983-0535.



works well in your office...

NEOSPORIN® Ointment (polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



Correspondence

FMA PRAISED FOR INVOLVEMENT

(Editor's Note: The following letter was sent to Sanford A. Mullen, M.D., President of the Florida Medical Association, and is reprinted here for the information of readers.)

Dear Dr. Mullen: I wish to acknowledge the Florida Medical Association for its total involvement regarding the optometric drug bill during the recent legislative session. The extensive activities of the Jacksonville and Tallahassee offices with the legislature on behalf of all physicians, and in particular Florida's ophthalmologists, demonstrate the Association's commitment to protect the public and medical profession from the attempts of non-medical providers to expand into the practice of medicine.

While optometry has done little to broadly educate all its members in matters pertaining to the diagnosis and treatment of diseases, including the use of drugs, it has none-the-less waged strong and sometimes effective legislative programs at the national and state levels to gain by legislation what it has not gained by education. Optometry's failure to pass their drug bill in Florida not only protects the people of Florida from a lowering of the quality of medical care, but provides an impetus to physicians elsewhere to wage an effective battle against similar threats in their states.

We are not so naive to believe the issue dead. It will arise again, and soon. All of Florida's physicians must recognize that if optometry gains the privilege of using and prescribing drugs without medical supervision by legislative fiat, others are eagerly waiting to follow the same course of action. We must be prepared to again respond to all attempts by non-medical providers to pass legislation favorable to only themselves.

The Florida Society of Ophthalmology thanks the Florida Medical Association, staff and the many indi-

vidual physicians throughout Florida who gave so generously of their time at great cost to their practices to help defeat the optometric drug bill. We look forward to continued cooperation between our two organizations in all areas pertaining to quality medical care at fair costs to the public we serve.

*Ken R. Safko, M.D.
President
Florida Society of Ophthalmology*

HARE OF THE DOG

To the Editor: The editorial, "Human Experimentation Committee vs. Edward Jenner" (May, 1981), was an excellent way of showing the need to permit a measure of freedom to experiment if medical scientists are to continue to progress. Such committees should not be allowed to stifle progress by nit-picking scientists with unnecessary requirements when they are committed to help people stay healthy. In the interest of accuracy in *The Journal of the Florida Medical Association*, I must, however, call to your attention the following facts: In 1881, (100 years ago) Louis Pasteur selected the rabbit as the most suitable animal for the passage and transmission of rabies virus and the attenuation by drying the total C.N.S. cord and medulla. He used, in 1885, rabbit medullas, dessicated, in which the virus had become attenuated enough to use as a means of immunizing animals. In no case did Pasteur "treat with an extract of rabid dog brain humans who had been bitten by a rabid dog" as was suggested in the editorial.

Personally, I am pleased Pasteur did not do what the editorial suggested. The results, had he used the rabid

dog brain, would have been successful only in proving that an extract of rabid dog brain when injected into humans, bitten by a rabid dog, could, if sufficient material were used, guarantee the human so injected would come down with a full blown case of rabies. This, of course, would have been good reason to have activated a "Human Experimentation Committee" long before medical science was encumbered by same. Pasteur, of course, did take *Rabid Rabbit C.N.S.* material, dessicated for varying times, from which he prepared the vaccine, which he did successfully use to prevent rabies infection in humans and animals.

Aside from my "nit-picking", of dog brain vs. rabbit brain, Dr. Kitchens is to be congratulated for putting the main issue in perspective, namely that to advance medical science will always necessitate the taking of risks — risks to the persons experimented upon, risks to the experimenter personally and to his/her career. It was a great editorial!

*Oscar Sussman, D.V.M., M.P.H., J.D.
Associate State Epidemiologist/Veterinarian
Epidemiology/Communicable Disease Program
Health Program Office*

This publication is available in microform.



University Microfilms International

Please send additional information
for _____

(name of publication)

Name _____
Institution _____
Street _____
City _____
State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England



Dr. Petty

The appointment of **R. William Petty, M.D.** . . . as Chairman of the Department of Orthopedic Surgery at the University of Florida College of Medicine has been announced by Dean William B. Deal, M.D.

Dr. Petty, whose principal interest is in arthritis and joint replacement, succeeds **William Enneking, M.D.**, who stepped down from the position last year. Dr. Enneking, the Eugene L.

Jewett Professor of Orthopaedics, will continue his research, teaching and patient care responsibilities.

The new Chairman received his M.D. degree from the University of Arkansas and took his orthopedic residency at the Mayo Clinic. He had advanced training in pediatric orthopedics at the Gillette Children's Hospital in St. Paul. He joined the UF faculty in 1975.

Seven Florida physicians . . . have joined the American College of Radiology. The new members of the ACR are: **Robert F. Basilico, M.D.**, Ft. Pierce; **Edward A. Dauer, M.D.**, Ft. Lauderdale; **Jon J. Halpern, M.D.**, and **David L. Harr, M.D.**, both of Miami; **Jose A. Rodriguez Jr., M.D.**, Coral Gables; **Michael L. Safer, M.D.**, Jacksonville; and **Joseph T. Witek, Tampa.**

Pedro Barquin, M.D., of Miami Springs . . . has been elected National United States Delegate of the Ibero Latin-American College of Dermatology for the term 1981-1983.

Frank H. Netter, M.D. . . . internationally-known medical illustrator, was recently awarded an honorary doctor of science degree by the College of Medicine and Dentistry of New Jersey. Dr. Netter, who has been associated with CIBA Pharmaceutical Company since 1938 and is widely recognized for his CIBA Collection of Medical Illustrations, has produced covers for three special issues of *The Journal*.

Three prominent FMA members . . . all former presidents of their county medical societies — have been installed in the three top offices of the Florida Academy of Family Physicians.

Arthur L. Eberly Jr., M.D., Pompano Beach, was installed as President of the Academy, while Immediate Past President **Kenneth C. Kiehl, M.D.**, Sarasota, assumes the position of Chairman of the Board. Jacksonville physician **Guy T. Selander, M.D.**, was named President-Elect.

As FMA members, Dr. Kiehl is the new Chairman of the Florida Medical Foundation's Committee on Peer Medical Utilization Review; Dr. Eberly is Chairman of the Council on Specialty Medicine; and Dr. Selander is serving a second year as Chairman of the Foundation's Committee on Impaired Physicians.

Also elected at the Academy's annual Scientific Assembly were **Kendall M. Beckman Jr., M.D.**, Melbourne, Vice President; and **Richard W. Dodd, M.D.**, Daytona Beach, Secretary and Treasurer.

E. M. Papper, M.D., Miami . . . former Dean of the University of Miami School of Medicine, has been appointed as one of 20 living honorary fellows of the Faculty of Anesthetists of the Royal College of Surgeons in Great Britain.



FMA AUXILIARY

FMA Auxiliary News Capsules . . .



Ruth Coleman



Gloria Nunn

Mrs. Francis C. (Ruth) Coleman of Hillsborough County was installed the new president of the 5,200-member state medical auxiliary during its 54th Annual Convention held last May at the Diplomat Hotel in Hollywood-By-The-Sea, Florida. This year, she asks that auxiliary members become a "Galaxy of Stars — to light the skies with excellence!" In seeking excellence, she points to the past for guidelines as one sets the goals for the future. "Excellence", she says, "means attention to the fine details that make a "good" thing "better."

Mrs. Daniel B. (Gloria) Nunn was named President-Elect.

Russ Berge has been appointed the new Executive Director of the FMA Auxiliary. He succeeds Mrs. Wanda McDermion. Prior to assuming this position, Mr. Berge was the FMA Representative for Central Florida for 3½ years, serving as liaison for local medical societies in a 19-county area.

Fifteen Delegates from Florida attended the 58th National Convention of the AMA Auxiliary held last June in Chicago.

FMAA Past President **Mrs. Linus W. (Jane) Hewit** of Tampa was elected National Treasurer, a position which puts her in the National Executive Committee, on the Board of Directors, as well as on the Chairmanship of the Finance Committee of the powerful national auxiliary.

Keynote Speaker **Senator Paula Hawkins** praised Florida's state medical auxiliary's involvement in legislative activities. FMAA also received special recognition for its total AMA-ERF contribution, \$1,692,346.03, which surpassed last year's, and three awards for organizing three new county auxiliaries — Citrus/Hernando, Pasco, and Indian River.

The national auxiliary, led by newly-installed president **Mrs. Harry Dvorsky** of California, will continue its "Shape Up For Life" campaign theme combining "Nutrition", "Physical Fitness", and "Managing Stress".



FMAA Delegates to AMAA Convention — (Front, left to right): Nancy Smith, Connie Moore, Edie Epstein, Ruth Coleman, Gloria Nunn, Pat Thames, Marian Broadway; (Back, left to right): Terry Carver, Lillian Cook, Jody Jarrell, Russ Berge (FMA-A Executive Director), Candy Fischer, Bea George, Minnie Mullen, Marilyn Levine.

**SPECTRUM
EMERGENCY
CARE**

**PROFESSIONALLY CHALLENGING ...
PERSONALLY REWARDING ...**

FLORIDA

SPECTRUM EMERGENCY CARE, dedicated to quality health care, is the leader in the management and staffing of over 220 emergency facilities in 33 states.

SPECTRUM currently offers opportunities throughout the STATE OF FLORIDA to qualified physicians who are seeking:

- * A guaranteed annual income - Production based bonus system.
- * Paid Professional Liability Insurance.
- * Flexible scheduling with regular hours; no on-call involvement.
- * Director and clinical positions; full and part-time opportunities.
- * Metropolitan and rural settings ... high and moderate annual patient visits.
- * Continuing medical education reimbursement; assistance with licensure expense.
- * Career growth potential.
- * Association with medical management experts in the emergency health care field.

Physician interviews are currently in progress. Inquiries are invited by contacting Mr. John Kutchback toll-free at 1-800-325-3982 or by forwarding credentials in complete confidence to Spectrum Emergency Care, Inc., 970 Executive Parkway, St. Louis, MO 63141.

MICROSURGERY COURSES

The Microsurgery Laboratory at the University of Florida offers three and five day courses aimed at teaching techniques applicable to:

Extracranial to Intracranial Bypass
Digital Reimplantation
Tubal Reanastomosis
Vasovasostomy
Transsphenoidal Surgery
Temporal Bone Dissection
Other Microsurgical Operations

For Information write:

Mrs. Cindy Brady
Microsurgery Laboratory
Box J265
University of Florida Health Center
Gainesville, FL 32610

The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment



**CONVENTION
PRESS, INC.**

2111 NORTH LIBERTY ST.

**JACKSONVILLE,
FLORIDA 32206**

PHONE 904/354-5555

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate^{*} Dospan^{*} ^{IV} (diethylpropion hydrochloride USP)

75 mg controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "... anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

Merrell Dow

^{*}Registered Trademarks of MERRELL-NATIONAL LABORATORIES Inc., Cayey, Puerto Rico 00633

References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride. In *Central Mechanisms of Anorectic Drugs*, S. Garattini and R. Samanin, Ed., New York. Raven Press, 1978, pp. 391-404

Tenuate^{*} ^{IV}
(diethylpropion hydrochloride USP)

Tenuate Dospan^{*} ^{IV}
(diethylpropion hydrochloride USP)
controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecostasia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine[®]) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

Licensee of Merrell[®]

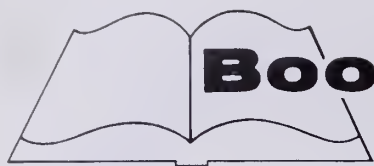
MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:

Merrell



MERRELL DOW PHARMACEUTICALS INC.
Subsidiary of The Dow Chemical Company
Cincinnati, OH 45215 • U.S.A.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Healing and History: Essays for George Rosen, edited by Charles E. Rosenberg. 262 Pages. Price \$22.75. Science History Publications/USA, Division of Neale Watson Academic Publications, Inc., New York, 1979.

Medical and social historian, an editor of *Ciba Symposia*, one of the founders of *The Journal of the History of Medicine and Allied Sciences*, editor of *American Journal of Public Health*, professor at Columbia and Yale, interpreter during the interrogation of Nazi generals in London at the end of WW II, Dr. George Rosen had a significant influence on medicine and medical history.

Healing and History consists of sixteen papers written by persons whose lives have been influenced by the distinguished Dr. Rosen. The book was intended as a festschrift to be published prior to his retirement as Professor of Medical History at Yale. Because of Dr. Rosen's unexpected death in 1977, this book became a memorial volume.

Fourteen papers deal with varied topics in medical history. These include, for example, Medical Ethics and Honoraria in Late Antiquity; Florence Nightingale on Contagion; The Hospital as Moral Universe; "All According to the Constitooshun": Charles Dickens and Lead Poisoning; and a review of the progress of *The American Journal of Public Health*, 1957-1973.

The two papers which deal with the life and influence of George Rosen, however, lead me to write more in detail. Charles E. Rosenberg of the University of Pennsylvania and editor of this volume and Saul Benison of the University of Cincinnati each give complementary summaries of Rosen's life and work.

Rosen was born in Brooklyn of Jewish immigrant parents. He attended a school for academically talented students in the New York Public School system. However, in the late 1920's it was difficult for some Jewish students, no matter how bright, to gain acceptance to medical school. Consequently, he sought and gained admission to medical school in Berlin. Not being able to speak German, he learned the language in order to attend his classes. He was able to see at first-hand "the danger to the human spirit and to life itself, in the then rising tide of Nazism." However, the experience of medi-

cal school in Berlin allowed him to meet his future wife Beata Caspari who became his life-long helpmate and he was introduced to the history of medicine.

Then German medical students were required to write a thesis in order to graduate. His German professor suggested that he write Dr. Henry Sigerist who was then director of the Institute for the History of Medicine at Johns Hopkins. Sigerist suggested that Rosen choose as his subject the European reception of William Beaumont, the American physician-physiologist, on gastric secretion. The resulting paper was an outstanding documentation of the European reception and it "also traced in detail the influence of that work on the subsequent development of gastric physiology and pathology."

Of interest is the fact that Dr. Rosen was unsuccessful in his practice of ophthalmology and otolaryngology "in part because he alienated that large group of patients who often come to doctors' offices with nebulous complaints and no real illness."

Rosen subsequently joined the New York Department of Health. His work in this area was seminal in his later work. Among these influences was a collaboration with Henry Sigerist on further areas of research, translation from the German, Jaboc Henle's *On Miasmata and Contagia*. Later, Rosen published his first major subject on pulmonary disease, *A History of Miner's Diseases*, also originally suggested by Sigerist.

Because of Rosen's translating ability, he was contacted by Ciba to translate the German language version of *Ciba Symposia*, published in Switzerland. The first few editions were merely translations. However, Rosen and his wife Beata as co-editors produced *Ciba Symposia*, between 1938 and 1944, editions of outstanding original quality. "Not only were the Symposia beautifully written and researched, they were superbly illustrated as well, reflecting Dr. Rosen's deep conviction of the importance of paintings and photographs as historical documents in their own right."

In 1946, Rosen published a now-classic paper on "Fee and Fee Bills" which examines the economic aspects of medical practice in nineteenth-century America. Rosen served in WW II as a medical intelligence officer, Division of Preventive Medicine, Surgeon General's Office, European Theater. At the end of the war, he

served as interpreter for the interrogation of Nazi generals in London.

Benison states that, "As editor of *The Journal of the History of Medicine and Allied Sciences* and as editor and member of the editorial board of the *American Journal of Public Health* (from 1948 to 1973), he literally instructed a post-war generation of medical historians and sociologists and thousands of public health workers and physicians in the history and sociology of medicine.

This volume is a fitting tribute to an outstanding medical writer, teacher, historian and sociologist.

F.N.V.

Medicine Without Doctors, edited by Guenter B. Risse, Ronald L. Numbers and Judith Walzer Leavitt. 124 Pages. Price \$5.95. Science History Publications/USA Division of Neale Watson Academic Publications, Inc., New York, 1977.

Five papers on self-help medicine comprise this brief but scholarly work. The papers were originally delivered at a symposium in 1975 sponsored by the Department of the History of Medicine, University of Wisconsin.

John B. Blake, Chief of the History of Medicine Division, National Library of Medicine, traces the literature of domestic medicine in America from the appearance of William Buchan's *Domestic Medicine*, published in Edinburgh in 1769 to Morris Fishbein's *Modern Home Medical Adviser*, first published in 1935. Buchan's book was the earliest comprehensive treatise of its kind in English. It did not purport to teach each person to be his own physician but gave the elements of self-help, hygiene, nutrition and first-aid. Buchan wrote that the role of medicine was "gradually to assist nature in removing the cause of the disease." Blake states that this approach is much more moderate for that time and represents an enlightened therapeutic outlook. After the American Revolution, Buchan's book was revised by Dr. Samuel P. Griffiths of the University of Pennsylvania. Griffiths added a chapter on yellow fever and made occasional notes on American practice.

Subsequently, several American authors published self-help medical books. Among them were *American Family Physician*, by Thomas Ewell, 1824; *American Medical Guide for the Use of Families*, by Thomas W. Ruble, M.D., 1810 and *Treatise on Domestic Medicine*, by Dr. William Matthews in 1948. Matthews' book "moved still further away from the heroic self-reliance of most of his predecessors." Matthews stated that the purges and emetics, commonly used in that day, were often improper; he advised calling a physician. He wrote, "The public are too fond of taking medicine and are apt to attribute too much to its curative influence. Medicine,

like every thing else, is good in its place but it is not always, under all circumstances, good to make Apothecaries' Shops of people's stomachs!"

Blake covers the developments of various self-help books and states that Dr. Fishbein's *Modern Home Medical Adviser*, appearing in 1934, reinforced a trend which was already well established.

Blake states, "From Buchan in 1769 to Fishbein in 1934, domestic medicine books of medical practice for those who could not obtain the services of a physician, with usually, some rules of hygiene, to informational or educational books about health and disease, with the do-it-yourself aspects strictly limited to hygiene and emergency first aid. In the process, they also mirrored changes in medical science and practice itself."

James H. Cassedy of the National Library of Medicine traced some of the causes for the necessity for self-help. Some of these included geographic isolation, poverty, and distrust of physicians. The westward migration of settlers, described by a clergyman of the time, produced "scenes of suffering . . . so frequent and familiar, as to have lost their natural tendency to produce sympathy and commiseration."

Ronald Numbers of the University of Wisconsin traced the influences of various sects, including botanics and eclectics, homeopaths, movement-curers and mind-curers among a host of others, on home medicine. One of the most successful and influential was a New Hampshire farmer, Samuel Thompson. By 1840, Thompson estimated that three million families had adopted his system.

Regina Morantz of the University of Kansas discusses women and health reform especially in the nineteenth century.

The last paper in this brief book is in some ways the most interesting. James H. Yonge, Professor of History, Emory University, covers the role of patent medicines in the self-help situation. He quotes Oliver Wendell Holmes' statement, "Somebody buys all the quack medicines that build palaces for the mushroom, say rather, the toadstool millionaires." He reminds us, also, of the oft-quoted line from Voltaire that quackery began when the first knave met the first fool. Young points out that shortly after advent of the printing press, nostrum ads began to appear. *Mercurius Politicus*, an English journal in 1616, "touted a dentifrice which would make the teeth 'white as ivory,' fasten them firmly, prevent toothache, sweeten the breath, and banish cankers."

Young goes into some detail about the life of Lydia Pinkham and the marketing of Lydia Pinkham's Vegetable Compound.

Mrs. Pinkham had struggled to maintain her family of three sons and a daughter hoping that her husband Isaac's speculations in real estate would make their future

secure. When the panic, or depression, of 1873 struck, Mrs. Pinkham was aged 54. Having taken an interest in home remedies and botanicals all her life, Mrs. Pinkham had a local reputation for good home remedies. She dosed family and friends, and occasionally strangers would show up at her door with requests for medicines, having heard of her skill through acquaintances.

With the help of her entire family, she began filling the Vegetable Compound bottles in her cellar kitchen in Lynn, Massachusetts. Though Mrs. Pinkham espoused temperance, her Vegetable Compound contained 18 percent alcohol.

"Only a woman understands a woman's ills" became her advertising slogan.

The Pinkham sons noted that the market for kidney complaints and male difficulty had not been covered, "And so the Pinkham pamphlets began to promote the Compound for kidney complaints of both sexes and for ailments of men's generative organs as well."

Young makes these observations, "The maker of bottled self-help seldom strays from a prime goal, whatever his other purposes may be: to maximize sales. He has constantly . . . observed what potential customers are suffering from in order to frame claims for what his patent medicine can do. The mercenary motive, of course, must never show. Instead, promoters presented themselves as the people's friend, the good samaritan, the ministering angel. But the basic drive for profit was always there. This still holds true in a proprietary medicine climate vastly different from that of a century ago." To this, we can only add Amen.

F.N.V.

The Harvard Medical School Health Letter Book, by G. Timothy Johnson, M.D. and Stephen E. Goldfinger, M.D. 444 Pages. Price \$15.95. Harvard University Press, Cambridge, Massachusetts, 1981.

Second Opinion, by Isadore Rosenfeld, M.D. 398 Pages. Price \$14.95. The Linden Press/Simon and Schuster, New York, 1981.

Both the *Health Letter Book* and *Second Opinion* gave advice written for the layman on relatively common medical subjects such as high blood pressure, hepatitis, cataracts, heart disease, hiatus hernia and diabetes.

Both these books can be recommended for that segment of the public who are discriminating readers, evaluate the opinion of the author and then think for themselves. Both books give good advice and good medical information which can make for a better educated patient.

The *Health Letter Book* is an updated summary of the information sent to subscribers of the Harvard Medi-

cal School Health Letter from its beginning six years ago. The writing is a bit more tightly edited and there are occasional line drawings which are helpful for the reader. One of the editors, Timothy Johnson is a syndicated health columnist who frequently appears on morning TV to discuss health matters.

Second Opinion is essentially a single-author book by Isadore Rosenfeld, cardiologist, medical writer and private practitioner. Dr. Rosenfeld acknowledges obtaining second opinions on many subjects outside his field of primary interest. There are catchy titles and subheads suggested, I suspect, by a marketing expert at the publishers. For example, the chapter head for diabetes is entitled, "Diabetes Mellitus — When Life is Too Sweet."

Either book could be recommended for your patients who wish to be better informed on medical subjects. My personal preference would be the *Health Letter Book*.

F.N.V.

Books Received

Receipt of the following books is acknowledged.

Jane Brody's Nutrition Book by Jane Brody. 55 Pages. Illustrated. Price \$17.95. W.W. Norton & Company, New York, 1981.

What To Do When You Think You Can't Have A Baby by Karol White. 215 Pages. Price \$11.95. Doubleday & Company, New York, 1981.

Practical Paramedical Procedures by Jonathan Wasserberger, M.D., and David H. Eubanks, Ed.D., R.R.T., R.E.M.T. 222 Pages. Illustrated. Price \$11.95 (paper). The C.V. Mosby Company, St. Louis, 1981.

Is Vasectomy Safe? by H.J. Roberts, M.D. 289 Pages. Illustrated. Sunshine Academic Press, West Palm Beach, 1981.

Nutrition and Medical Practice, edited by Lewis A. Barness, M.D., Yank D. Coble Jr., M.D., Donald I. MacDonald, M.D., and George Christakis, M.D., M.P.H. 408 Pages. Illustrated. Price \$17.50. Avi Publishing Company, Inc., Westport, Conn., 1981.

The Complete Guide to Preparing Baby Foods by Sue Castle. 336 Pages. Price \$13.95. Doubleday & Company, New York, 1981.

Current Surgical Diagnosis and Treatment, Fifth Edition edited by J. Englebert Dunphy, M.D. and Lawrence W. Way, M.D. 1,138 Pages. Illustrated. Price \$25.00. Lange Medical Publications, Los Altos, Calif., 1981.

Caution: "Kindness" Can Be Dangerous to the Alcoholic by Abraham J. Twerski, M.D. 174 Pages. Price \$9.95. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1981.

Atlas of Medicinal Plants of Middle America by Julia F. Morton, D.Sc., F.L.S. 1,420 Pages. Illustrated. Price \$147.50. Charles C. Thomas, Springfield, Ill., 1981.

Night Thoughts, Reflections of a Sex Therapist by Avodah K.

Offit, M.D. 256 Pages. Price \$12.95. Congdon and Lattes, Inc., New York, 1981.

Review of Medical Physiology by W.F. Ganong, M.D. 628 Pages. Illustrated. Price \$17.00. Lange Medical Publications, Los Altos, Calif., 1981.

The Changing Years, Menopause Without Fear by Madeline Gray. 277 Pages. Price \$13.95. Doubleday & Company, Inc., New York, 1981.

Medical Decorators

NEW OR EXISTING SPACE
PROFESSIONALS WORKING
AROUND YOUR SCHEDULE

(305) 772-0090
By Appointment

CARY MARTIN
5055 N.E. 13 Ave.
Fort Lauderdale, Fla. 33334

An apple a day won't keep alcoholism away!

The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

Do you have a patient who needs this kind of help? You probably do because the illness is sneaky. For more information and guidelines on how to identify these patients, write to us.

Willingway Hospital

311 JONES MILL ROAD
STATESBORO, GA. 30458

(912) 764-6236

J.C.A.H. ACCREDITED

Deaths

Anderson, Charles David, Clermont; born 1929; University of Nebraska, 1963; member AMA; died 1980.

Anderson, Egbert Vernon, Milton; born 1910; Emory University Medical School, 1937; member AMA; died May 19, 1981.

Bird, Donald Paul, Lakeland; born 1902; Allegheny College, 1925; died September 25, 1980.

Bonachea, Miguel Ramon, Belle Glade; born 1919; Havana University, 1945; died March 1980.

Brown, Schuyler Pillsbury, Treasure Island; born 1906; University of Minnesota, 1941; died 1981.

Calabia, Jose Amat, Apollo Beach; born 1934; University of St. Tomas, 1958; member AMA; died February 10, 1981.

***Cano, Miguel Angel**, Clewiston; born 1922; University of Havana, 1948; died 1980.

Carbonell, Gumercindo, Tampa; born 1926; Hahnemann Medical College, 1943; died September 13, 1980.

Crandall, Lathan A., Jr., Panama City; born 1903; Northwestern University School of Medicine, 1930; died December 23, 1980.

de Armendi, Carlos, Miami Beach; born 1914; University of Havana, 1945; died May 1980.

Dierdorf, Fred William, Pensacola; born 1925; Indiana University, 1950; member AMA; died November 10, 1980.

Farringer, Robert Hirst, Ft. Lauderdale; 1908; Hahnemann Medical School, 1933; died December 17, 1980.

Feldman, Sidney, Sunrise; born 1910; University of Hamburg, 1936; member AMA; died November 26, 1980.

Free, Richard Matthew, Pinellas Park; born 1901; Hahnemann Medical College, 1932; member AMA; died April 8, 1981.

Gold, Saul, Pembroke Pine; born 1940; New York Medical College, 1971; member AMA; died December 1980.

Goldstein, Leonard, Lake Worth; born 1937; New York Medical College, 1966; Member AMA; died 1980.

Gonzalez, Angel Salvador, Margate; born 1926; University of Havana, 1953; died October 26, 1980.

Goodwin, Hugh Bascom, Ft. Pierce; born 1905; University of Tennessee, 1934; member AMA; died May 1981.

Graditor, Milton Harry, Hollywood; born 1912; Hahnemann Medical School, 1937; member AMA; died December 20, 1980.

Hendrickson, Floyd C., Sebring; born 1895; University of Cincinnati, 1921; died January 21, 1981.

Henry, Jimmy Farthing, Keystone Heights; born 1921; Washington University, 1944; died May 26, 1981.

Hitchcock, Edgar Earl, Orlando; born 1909; University of Georgia, 1935; died February 12, 1981.

Jennings, Lloyd Harlan, Starke; born 1910; University of Illinois, 1937; member AMA; died 1981.

Jones, Roderic Orlando, Sun City; born 1911; Duke University Medical School, 1936; member AMA; died May 8, 1981.

Kuhn, Harold Hunter, Big Pine Key; born 1914; Duke University, 1940; member AMA; died January 29, 1981.

Lamb, Samuel Rodolph, Jacksonville; born 1914; Harvard Medical School, 1944; member AMA; died October 8, 1980.

Link, Robert Jeffrey, Pensacola; born 1924; Duke University Medical School, 1953; member AMA; died April 11, 1981.

Linz, Frank Tressler, Tampa; born 1913; Ohio State University, 1938; died January 13, 1981.

FOR CORRECTION
840

Mark, Morton Field, Long Boat Key; born 1906; University of Chicago, 1933; member AMA; died January 25, 1981.

Mehl, Omar Clayton, Tampa; born 1911; University of Pittsburgh, 1936; died December 26, 1980.

Mellion, Anson Joel, Jacksonville; born 1921; New York Medical School, 1954; member AMA; died October 8, 1980.

Nelson, Robert Goree, Tampa; born 1893; Vanderbilt, 1918; member AMA; died 1980.

Netto, Lloyd Joseph, West Palm Beach; born 1895; Vanderbilt, 1924; member AMA; died November 12, 1980.

Odom, Robert Taft, Winter Garden; born 1908; University of Tennessee, 1934; died January 17, 1981.

Palmer, Thomas Myers, Jacksonville; born 1897; John Hopkins, Maryland, 1926; member AMA; died May 17, 1981.

Plyler, Cranford Oliver, Jacksonville; born 1927; George Washington University School of Medicine, 1953; member AMA; died December 6, 1980.

Pour-Hassani, Hossein, Ft. Lauderdale; born 1939; Oxford, 1966; died September 12, 1980.

Porto, Francisco P., Tampa; born 1923; Havana University, 1949; member AMA; died November 16, 1980.

Risbeck, Earl Cavell, Crescent City; born 1922; Columbia College P & S, 1951; member AMA; died December 27, 1980.

Rodriguez-Caceres, Luis, Miami; born 1899; Havana University, 1920; member AMA; died September, 1980.

Russell, Charles Edward, Rockledge; born 1912; Columbia University Medical School, 1941; member AMA; died July 4, 1980.

Schanck, George P., Orlando, 1909; Meharry Medical College, 1938; died October 27, 1980.

Schwinger, Robert, Ft. Lauderdale; born 1915; University of London, 1942; died January 22, 1981.

Serrano, Ernest Escarza, Hollywood; born 1913; Washington University, 1938; member AMA; died 1981.

Sheehy, Paul Lawrence, Tampa; born 1912; Meharry Medical College, 1950; died November 11, 1980.

Snelling, John McLucius, Clearwater; born 1918; Medical College of Georgia, 1943; member AMA; died February 19, 1981.

Stone, Daniel Lewis, Miami Beach; born 1924; Maryland, 1948; member AMA; died 1981.

Tuazon, Manuel V., St. Petersburg; born 1935; Manila Central University, 1965; died February 27, 1981.

Valin, Jack Louis, Ft. Lauderdale; born 1912; University of Cincinnati, 1937; member AMA; died October, 1979.

Wilson, Dale Sloan, Miami Springs; born 1914; Jefferson, 1940; member AMA; died 1980.

Wulfstat, Boas, Miami Beach; born 1911; Paris, 1939; member AMA; died 1980.

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule
contains:

Pentylenetetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Pyridoxine HCL 25 mg.
Glutamic Acid 50 mg.
Glutamine 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons ex-
perience a flushing and tingling
sensation after taking a higher
potency nicotinic acid. As a sec-
ondary reaction some will com-
plain of nausea, sweating and ab-

dominal cramps. The reaction is
usually transient.

INDICATIONS: As a cerebral
stimulant and vasodilator.

**RECOMMENDED GERIATRIC
DOSAGE:** One capsule three
times daily adjusted to the in-
dividual patient.

WARNING: Overdosage may
cause muscle tremor and convul-
sions.

CONTRAINDICATIONS: Epilepsy
or low convulsive threshold.

CAUTION: Federal law prohibits
dispensing without prescription.
Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

SEPTEMBER

Craniofacial Pain and Temporomandibular Joint Dysfunction: Differential Diagnosis, Treatment Modalities and Current Concepts, Sept. 3, Holiday Inn, Stuart. For information: Charles Fraraccio, M.D., 931 East Ocean Boulevard, Stuart 33494.

Craniofacial Pain and Temporomandibular Joint Dysfunction: Differential Diagnosis, Treatment Modalities, Current Concepts and MD/DDS Communication in this Field, Sept. 3, Holiday Inn, Stuart. For information: Charles Fraraccio, M.D., 931 East Ocean Boulevard, Stuart 33494.

Pediatric Neurology, Sept. 4-5, Sacred Heart Children's Auditorium, Sacred Heart Hospital, Pensacola. For information: Reed Bell, M.D., 5151 North Ninth Avenue, Pensacola 32504.

Department of Surgery Meeting, Sept. 8, St. Joseph Hospital, Port Charlotte. For information: Jane P. Ontog, R.N., M.S., 601 Northeast Harbor Boulevard, Port Charlotte 33952.

Conferences in General Medicine and Family Practice, Sept. 9, International Medical Center, HMO, Miami. For information: Alfredo Crucet, M.D., P.O. Box 016700, Miami 33101.

Newer Aspects of Pacing and Tachycardia Control, Sept. 12, Omni International Hotel, Miami. For information: John W. Lister, M.D., Professional Education Committee, American Heart Association of Greater Miami, 5220 Biscayne Boulevard, Miami 33137.

Intensive Review Course for Family Physicians, Sept. 14-18, Sheraton Sand Key, Clearwater. For information: Dr. Charles Aucremann, Box 13, 12901 North 30th Street, Tampa 33620.

Prevention and Treatment of Medical and Surgical Infections, Sept. 15, Martin Memorial Hospital, Stuart. For information: Charles A. Fraraccio, M.D., 931 East Ocean Boulevard, Stuart 33494.

Arthroscopy and Arthroscopic Surgery, Sept. 15, Dye Auditorium, Holy Cross Hospital, Fort Lauderdale. For information: Jon R. Fichtelman, M.D., P.O. Box 23460, Fort Lauderdale 33307.

**Indication and Implications of Office Pulmonary Function Test-
ing**, Sept. 17, Ft. Cooper Station Restaurant, Inverness. For infor-
mation: C. J. McGrew Jr., M.D., 2875 Keysville Avenue, Spring Hill 33526.

Topics in Neurology, Sept. 24-26, The Colony Beach and Tennis
Resort, Sarasota. For information: William D. Ertag, M.D., 201 8th
Street South, Naples 33940.

29th Annual Diabetes Seminar, Sept. 24-27, Don Cesar Hotel, St.
Petersburg. For information: Brendan C. O'Malley, M.D., Medical
Center, Diabetes Center, Box 45, 12901 North 30th Street, Tampa
33612.

OCTOBER

X-Ray Interpretation for the Primary Care and Emergency Physician, Oct. 1-4, St. Petersburg. For information: Sharon G. Llera, Administrative Assistant, Professional Services, Emergency Medical Services Assistants, 1400 66 Street, Suite 260, St. Petersburg 33710.

Parenting and Reparenting, Oct. 2, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Fort Walton Beach 32548.

Evaluation and Therapy of Shock and Drowning, Oct. 15, Ft. Myers. For information: Irwin J. Kash, M.D., Chairman, Department of Pediatrics, 3949 Evans Avenue, Suite 207, Ft. Myers 33901.

22nd Annual Workshop in Electrocardiography, Oct. 15-19, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, 601 12th Street, North, St. Petersburg 33705.

Current Concepts in Cardiac Rehabilitation, Oct. 21-23, Hilton Inn Florida Center, Orlando. For information: Zeb C. Bruton, M.D., 1230 East Hillcrest, Orlando 32803.

Occupational Health Managers on the Company Team, Oct. 23-24, Hilton Hotel, Jacksonville. For information: Mary Green, R.N., COHN, Southern Bell Employee Health Service, Jacobs Building, P.O. Box 390, Jacksonville 32201.

Applications of Psychiatry to Family Practice, Oct. 24, University of Florida, JHM Health Center, Gainesville. For information: Office of CME, University of Florida College of Medicine, Box J-233, JHM Health Center, Gainesville 32610.

NOVEMBER

Selected Topics in Cardiology, Nov. 4-6, Wolfson Auditorium, Miami Beach. For information: Philip Samet, M.D., 4300 Alton Road, Miami Beach 33140.

5th Annual Medical Aspects of Aging, Nov. 5-7, Gainesville Hilton, Gainesville. For information: Office of CME, University of Florida.

Clinical Management of Coronary Disease and Exercise Testing, Nov. 6-8, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood, CO 80112.

Management of the Arthritides: 1981, Nov. 12-14, Ponce de Leon Motor Hotel, St. Augustine. For information: Louis M. Sales, M.D., 1204 LeBaron Avenue, Jacksonville 32207.

14th Family Practice Review, Nov. 16-20, Hotel Royal Plaza, Lake Buena Vista. For information: Lamar Crevasse, M.D., Box J-233, JHM Health Center, Gainesville 32610.

The ABC's of Viral Hepatitis, Nov. 19, Ft. Cooper Station Restaurant, Inverness. For information: C. J. McGrew Jr., M.D., 2875 Keyville Avenue, Spring Hill 33526.

Multiple Sclerosis Update for Physicians in Practice, Nov. 20-23, Walt Disney World Conference Center, Lake Buena Vista. For information: Allen D. Roses, M.D., Professor and Chief, Division of Neurology, Duke University Medical Center, Durham, N.C. 27710.

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	..... 300 mg.
Ascorbic Acid	..... 150 mg.
Thiamine HCL (B-1)	..... 25 mg.
Riboflavin (B-2)	..... 2 mg.
Pyridoxine HCL (B-6)	..... 10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	..... 250 mg.
Niacinamide	..... 75 mg.
Ascorbic Acid	..... 150 mg.
Thiamine HCL (B-1)	..... 25 mg.
Riboflavin (B-2)	..... 2 mg.
Pyridoxine HCL (B-6)	..... 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	..... 100 mg.
Niacinamide	..... 75 mg.
Ascorbic Acid	..... 150 mg.
Thiamine HCL (B-1)	..... 25 mg.
Riboflavin (B-2)	..... 2 mg.
Pyridoxine HCL (B-6)	..... 10 mg.

DOSE: 1 to 5 tablets daily.


AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC. 
2500 West Sixth Street, Los Angeles, California 90057

**When painful spasm
is the presenting
symptom...**

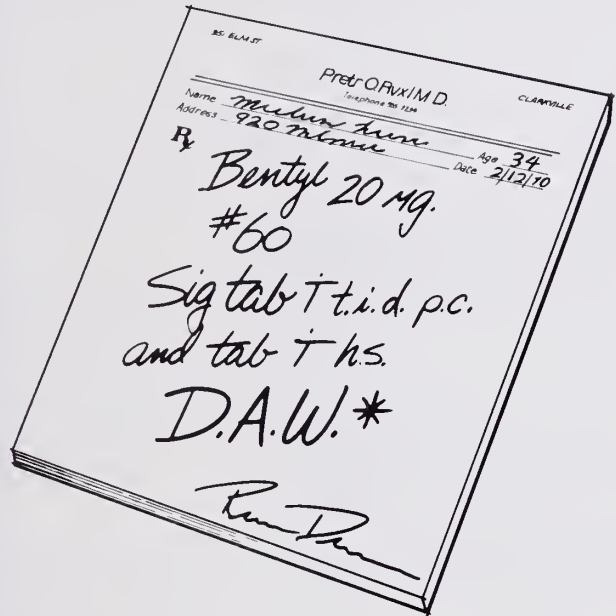


...in the functional bowel/irritable bowel syndrome*

be sure to specify

Bentyl[®]
(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



**D.A.W.-Dispense as written*

because:

- ⊕ The Bentyl molecule is a product of original Merrell research.
- ⊕ At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- ⊕ Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Significant pharmacologic effect in the distal colon compared to placebo,¹ shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:

¹ Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FOA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness, drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup. *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg. *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by

CONNAUGHT LABORATORIES, INC.

Swiftwater, Pennsylvania 18370 or

TAYLOR PHARMACAL COMPANY

Ocatator, Illinois 62525 for

Merrell



MERRELL DOW PHARMACEUTICALS INC.

Subsidiary of The Dow Chemical Company

Cincinnati, OH 45215 U.S.A.

1-7052 (Y368C)

MMQ-712

NME...

the "help you establish a successful practice" experts.

Our goal at National Medical Enterprises is to help you establish a comfortable and successful Primary Care practice.

Where you want it.

How you want it.

It's a goal we achieve by offering you a choice of over 60 well equipped acute care hospitals coast to coast, by offering you selected financial assistance, and by offering you management consulting when you begin your practice.

So whether you're interested in solo, partnership or a group practice, you should contact NME.

We're the experts!

For further information, contact:

Raymond C. Prullt, Director, Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.

Toll-Free 800-421-7470
or collect (213) 479-5526.

NATIONAL MEDICAL ENTERPRISES, INC.



"The Total Health Care Company."

An Equal Opportunity Employer M/F

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

MEDICAL OPHTHALMOLOGIST wanted for busy practice. No refraction or contact lens fitting. Ideal location in East Coast of Florida. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

WELL TRAINED Family Practitioner or Internist needed to join staff of a Family Medical Center in Jacksonville, Florida. Excellent opportunity for professional and economic growth. Respond with CV to: Susan Masterson, Emergency Medical Services Associates, Inc., 8200 W. Sunrise Boulevard, Building C, Plantation, Florida 33322, or phone (800) 327-0413.

FLORIDA — Aggressive group, fee-for-service, malpractice, group health insurance, teaching, EMS, opportunity for advancement. Contact Steve Watsky, M.D., 707 40th Street West, Palmetto, Florida 33561, (813) 722-1722 or P. Fagan Jr., M.D., Post Office Box 9639-FL, Marina Del Rey, California 90291, (213) 822-1312.

EMERGENCY MEDICINE opportunities throughout Florida: Directorship and clinical positions available to career-oriented emergency physicians in central and coastal areas. Excellent compensation, paid professional liability insurance, flexible scheduling to be awarded to physicians chosen. For details send credentials in complete confidence to Mary Obsitnik,

9100 Purdue, Suite 119, Indianapolis, IN 46268; or call collect (317) 875-7518.

INTERNIST TO JOIN established partnership practice, Orlando, Florida. Starting July 1981. Curriculum vitae to Internal Medicine Group, 1910 N. Orange Avenue, Orlando, Florida 32804.

FLORIDA — Pediatrician, must be Board certified — eligible, to associate with a busy, progressive practice, with excellent hospitals. Attractive and recreational area of Winter Park, and Orlando. Applicants are encouraged to submit a curriculum vitae to: Louis Spinelli, M.D., 100 Perth Lane, Winter Park, Florida 32792.

FP's NEEDED for ideally located office in north Palm Beach County, (Jupiter-Tequesta area). Also, space for ophthalmologist or dermatologist. Coverage and assistance available. Two open staff hospitals nearby for qualified M.D.'s. Call: (305) 746-2033.

FT. LAUDERDALE — Primary Care Facility actively recruiting ambitious physician. 40 hour week. Salary good. Ample time off. Call (305) 474-4403.

CHATTANOOGA, TENNESSEE — New Hospital recruiting one Family Practitioner, and one E. R. Physician to join established groups. Two additional Family Practitioners needed to develop a group practice in an under-doctored community (unique financial opportunity). One full-time Anesthesiologist needed for hospital (salary negotiable). All applicants must be board eligible, or certified for the above positions. If you want seasonal changes, excellent schools, a very low cost of living, and be close to Atlanta, Nashville, or the Smokey Mountains, this is an excellent opportunity. Please send your curriculum vitae with references to: C-1059, Post Office Box 2411, Jacksonville, Florida 32203.

MOORE HAVEN, FLORIDA — Population 4,000 (area). Agricultural — cattle; on Lake Okeechobee; nearest hospital is 15 miles away; no private physician. Call (813) 946-1212.

PSYCHIATRIST OPENINGS at Northeast Florida State Hospital near Jacksonville. Position as Service Center Directors, as Staff Psychiatrists, and also as physicians are now available. Assignments on General Adult Psychiatric Service, Geriatric Service, and Children's Service as well. Competitive salary and benefits. Affiliation with the University of Florida, Gainesville, EEO/AA. Please contact Clinical Director, Northeast Florida State Hospital, Hwy. 121, S., Macclenny, Florida 32063 or call (904) 259-6211, ext. 110.

FAMILY PRACTITIONER, GENERAL INTERNIST, PULMONARY INTERNIST Board certified to join multi-specialty group practice on west coast of Florida. Excellent salary leading to partnership. Send curriculum vitae to Michael T. Gossman, Community Health Center, 1150 Plaza Drive, New Port Richey, Florida 33553.

POSITION AVAILABLE AS MEDICAL DIRECTOR for the Ft. Lauderdale Inter-Continental Hotel and Spa at Bonaventure. Background and interest in sports medicine as well as nutrition preferred. Write C-1063, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED/QUALIFIED ORTHOPEDIC SURGEON associate needed. Busy, solo, Board Certified Orthopedist looking for professional assistance in pleasant, rural, growing central Florida community. Good school system. Varied outdoor recreation. Within 90 minutes of two Medical Center locations. Curriculum vitae requested. Contact R. DeWitt S. Jones, M.D., 305 North Apopka Avenue, Inverness, Florida 32650.

MULTI-SPECIALTY GROUP PRACTICE now being formed in new medical center in West Palm Beach, Florida. Will open on or about March 1982. High income potential, salary and profit sharing. Positions still available. If interested, please forward resume to Mathew I. Gelfand, M.D.P.C., 718 East Park Avenue, Long Beach, New York 11561.

COMPHEALTH · LOCUM TENENS — Physicians covering physicians, nation-

wide, all specialties. We provide cost effective quality care. Call us day or night. T.C. Kolff, M.D., President, Comphealth, 175 West 200 South, Salt Lake City, Utah 84101, (801) 532-1200.

PHYSICIANS WANTED: non-clinical disability evaluation medical consultation for Social Security. Full time, 40 hour work week. Knowledge of electrocardiographic interpretation desirable. Write or call G. M. Davis, State Medical Consultant, 3437 Lawton Road, Suite 127, Orlando, Florida 32803; (305) 896-4691.

PSYCHIATRIST NEEDED for a full-time position with our Outpatient Program, 15-bed Crisis Stabilization Unit and 90-bed Geriatric Residential Center. Florida License (or eligibility) required. Private practice and consulting opportunity available. Responsibilities include intake diagnosis, treatment and discharge, rotating on-call duty, and outpatient consulting for psychiatric medications. Salary range good. For more information, contact the Personnel Department, Santa Rosa County Mental Health and Rehabilitation Facility, Inc., 400 Stewart Street, N.E., Milton, Florida 32570. EEO.

FAMILY PRACTITIONER OR INTERNIST WANTED to provide a fee for service type of care for a large St. Petersburg condominium complex and surrounding area. A spacious medical center is available with five nurses providing 24 hour service. Ideal for a retired physician. Contact T. R. VanDell, M.D., 5200 Brittany Drive South, St. Petersburg, Florida 33715 or call (813) 867-3513.

FAMILY PRACTICE ASSOCIATE — Preferably Diplomate AAFP, to assume Hospital, Nursing Home, Night Calls, as well as Office Practice. 64 year old AAFP physically limited to office practice. Five minutes from two hospitals. Excellent office staff. Former associate leaving mid-June for Residency. Address curriculum vitae to Donald E. Fortner, M.D., 5800 S.W. 73rd Street, South Miami, Florida 33143.

Situations Wanted

GENERAL, COLON AND RECTUM SURGEON, trained in Colonoscopy, Board eligible, 35, seeks position in Florida to practice either one specialty or both.

Speaks Spanish fluently. Available October 1981. Contact: Luis F. Espallat, M.D., 1517 Texas Avenue, Homestead AFB, Florida 33039. Phone (305) 257-2870.

MEDICAL OPHTHALMOLOGY: 43 year old American Board certified, desires satisfactory position in established practice. Will consider all locations. Curriculum Vitae on request. C-1051, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED (AP & CP). Experienced. Seeking the position of hospital based associate or assistant pathologist in the Florida State. Available immediately. Contact: C-1060, Post Office Box 2411, Jacksonville, Florida 32203.

ADULT AND PEDIATRIC UROLOGIST — 38-year-old Board certified Florida native, experienced in fertility and microsurgery seeks partnership, group or solo practice. Reply: C-1061, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON, 34, board qualified, with Florida license, seeking relocation. All areas considered. Reply: A. Gutierrez, M.D., 213 W. New Jersey Ave., Somers Point, New Jersey 08244. Phone: (609) 653-1117.

WANTED IMMEDIATELY - LOCUM TENENS with possibility of partnership or purchase of practice — full time family practice and surgery. John N. Sims, M.D., 601 N. Sixth Street, Ft. Pierce, Florida 33450.

OB-GYN. BOARD ELIGIBLE, SEEKS SOLO, GROUP OR HOSPITAL PRACTICE. Available immediately. Phone (212) 467-0532 or (212) 274-5894.

BOARD CERTIFIED FAMILY PRACTITIONER; Board Eligible ER; clean record 23 years experience desires full or part time salary position in clinic, ER, or teaching in Central or N.E. Florida. Write C-1064, P.O. Box 2411, Jacksonville, Florida 32203.

Practices Available

GENERAL PRACTICE — Ft. Myers, Florida. Chance of a lifetime. Lucrative established practice for sale. Well equipped newly decorated office in professional

building centrally located in rapidly expanding growth city. (813) 482-6779 or reply C-1062, Post Office Box 2411, Jacksonville, Florida 32203.

PRACTICE FOR SALE — 3½ years. General Internal Medicine; active; Office adjacent to 350-bed hospital. Negotiable terms. Call (813) 522-4611 after 7 p.m.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

TO SUBLET — Medical office space in prime Medical Office Building. Convenient to St. Joseph's and Women's Hospital, 4700 N. Habana Avenue, Tampa, Florida; 1,550 square feet, well partitioned office, four exam rooms, two consultation rooms, lab and business office. Suitable for almost any specialty. Call (813) 877-7434.

FORT LAUDERDALE: OUTSTANDING LOCATION: Two offices with attached elegant home, which is convertible to clinic, 5,200 square feet, corner, good parking. Opposite Galleria Shopping Center, good terms. 2600 N.E. 9th Street, (305) 561-3843.

TAMPA, MEDICAL FACILITY FOR SALE. Modern fully equipped medical clinic — 7,000 square feet with 4 private offices, 12 examination rooms, brick constructed, 5 years old, located in the most prestigious and fastest growing community in Hillsborough County. Perfect for group practice and/or condo conversions. Many outstanding features. Contact Charles Futch, REALTYCORP of Tampa, (813) 251-8451.

LAGO VISTA EXECUTIVE CENTER, 8019 N. Himes Avenue, Suite 300, Tampa, Florida 33614. 1,500 square feet, suitable for doctor. Quiet, pleasant atmosphere, overlooking landscaped lake. Convenient location. (813) 933-5100.

TAMPA BAY AREA — Clearwater, Florida — Two new, one story, medical

office buildings available in "Harrison Square" Medical Center. Unusually attractive, eight building complex across from Morton Plant Hospital. Lease or sale. Attractive financing available. Contact Atkinson-Van Horn Associates, Licensed Real Estate Broker, 2280 US 19 N., Suite 161, Clearwater, Florida. (813) 796-3903.

PROFESSIONAL SPACE FOR LEASE, 840 square feet. Fastest growing area of Pasco County. Surrounded by 5,000 plus new homes. Unique location near new hospital. Reasonable rent. (813) 862-2184 / 868-6271.

DOCTORS WANTED — NEW PROFESSIONAL OFFICES. 1,000 square foot suites will be completed 9/81 in West Lake County. Community of 7,000. Popular. Please call anytime: (305) 339-9462.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Col, 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Services

DOCTOR, WE KNOW YOUR BUSINESS. With 27 years experience as a hospital administrator and being raised in a Doctor Family, Bill Bishop, FACHA, understands your needs! He specializes in recruitment and placement of doctors in Florida. Bill Bishop and Associates, Inc., Health Care Executive and Physician Search Consultant, 1045 Riverside Ave., Jacksonville, Florida 32204, (904) 354-1050.

Meetings

SNOWMASS/VAIL "MEP" SKI SEMINAR on management Enrichment for the Health Professional. Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or Ski Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Seminars comply with IRS rules to make trip expenses deductible for doctor and spouse. For brochure and lodging information contact: M.E.P., An Education Corporation, 906 Cooper Avenue, Glenwood Springs, Colorado 81601; or call (800) 525-3402.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

When
Impotence
is due to androgenic deficiency.

Android 5^{Buccal} / 10^{Oral} / 25^{Oral}
Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide: In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric, Drug Therapy, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

Write for new double blind study reprints and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Advertisers

Boots Pharmaceuticals F-E-P Creme, Su-Ton, Twin-K, Twin-K-Cl 622a	National Medical Enterprises Service 678
Brown Pharmaceuticals Cerebro-Nicin 674 Lipo-Nicin 675 Android 681	Pennwalt Pharmaceuticals Zaroxolyn 622a
Burroughs Wellcome Neosporin Topicals 661	Spectrum Emergency Care, Inc. Service 666
Convention Press Service 666	Roche Laboratories Valium 606 Bactrim 683
Cary Martin Decorating 671	Royco Medical Equipment 622
DAC Corporation Service 616	The Upjohn Company Motrin 666a
Florida National Banks Service 607	University of Florida Meeting 666
Geriatric Pharmaceutical Co. B-C-Bid 612	University of Miami Meetings 610,618
Hedeco Entero-Test 621	Wetzel Service 615
Eli Lilly & Company Ceclor 608	Willingway Hospital Service 671
Merrell Dow Pharmaceuticals Bentyl 676 Tenuate 666a	Wyeth Laboratories Cyclapen-W 610 Ativan 616 Equagesic 666a Wygesic 666a

Florida Medical Association Officers and Council Chairmen

Officers

Sanford A. Mullen, M.D., Jacksonville, President
 Robert E. Windom, M.D., Sarasota, President-Elect
 Gerold L. Schiebler, M.D., Gainesville, Vice President
 Luis M. Perez, M.D., Sanford, Secretary
 J. Russell Forlaw, M.D., Boynton Beach, Treasurer
 T. Byron Thames, M.D., Orlando, Immediate Past-President
 James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
 Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
 W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
 Louis C. Murray, M.D., Orlando, Legislation
 Charles P. Hayes, M.D., Jacksonville, Health Care Financing
 Joseph T. Ostroski, M.D., Miami, Medical Services
 Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
 Arthur L. Eberly, M.D., Lighthouse Point, Specialty Medicine



SPECIAL ISSUE

University of South Florida College of Medicine

GUEST EDITOR

Donn L. Smith, M.D., PhD



Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to decrease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgeable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ®, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spastically caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

PROFIT FROM OUR EXPERIENCE

For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

We specialize in attaining the results that you require from your account in the areas of:

● **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.

● **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.

● **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

PEOPLE WHO KNOW HOW.

Florida National Trust Services



214 Hogan Street
Jacksonville, Florida 32231
Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC

REINSURANCE BROKERS for Florida Physicians Insurance Reciprocal —serving physicians throughout Florida



**The
Wetzel
Company,
Inc.**

P.O. Box 66452 · Houston, Texas 77006



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

SEPTEMBER 1981 • VOL 68 • NO. 9 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.
E. Charlton Prather, M.D.

Assistant Editors

Francis C. Coleman, M.D.
James K. Conn, M.D.
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
Norman M. Kenyon, M.D.
(from Board of Governors)
Edward Pedrero Jr., M.D.

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Susan L. Milhoan

Consulting Editorial Staff

Fuad S. Ashkar, M.D.	Karl J. Kramer, M.D.
Thomas D. Bartley, M.D.	R. G. Lacsamana, M.D.
Robert L. Batey, M.D.	Richard F. Lockey, M.D.
Pierre J. Bouis Jr., M.D.	Phllander D. Morgan, M.D.
Ms. Deborah B. Wilbur	George Morris, M.D.
William T. Branch, M.D.	George A. Neder Jr., M.D.
Miguel A. Brito, Jr.	Richard S. Panush, M.D.
Elmer B. Campbell, M.D.	R. A. Penalver, M.D.
Manuel L. Carbonell, M.D.	John K. Petrakis, M.D.
Ronald W. Case, M.D.	Phillip B. Phillips, M.D.
Toni Charneco	Michael R. Redmond, M.D.
Louis E. Cimino, M.D.	Albert L. Rhoton, M.D.
Charles Craig, M.D.	James F. Richards Jr., M.D.
R. Jay Cummings Jr., M.D.	Arvey I. Rogers, M.D.
Raul deVelasco, M.D.	William J. Romanos Jr., M.D.
James E. Deming	Lees M. Schadel, M.D.
Pablo Enriquez, M.D.	Frederick W. Schert, M.D.
Robert F. Feltman, M.D.	Guy T. Selander, M.D.
Richard Feinstein, M.D.	Roberto A. Sosa, M.D.
Lawrence M. Fishman, M.D.	John Stone, M.D.
Allan L. Goldman, M.D.	Robert H. Threlkel, M.D.
Henry L. Harrell, M.D.	Benjamin E. Victorica, M.D.
Allan Herskowitz, M.D.	Thomas M. Wiley, M.D.
James T. Howell, M.D.	Charles D. Williams, M.D.
Rubin Klein, M.D.	Frederic C. Wurtzel, M.D.

Subscription Rate: \$15.00 per year, single copy. \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917: authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

Special Issue on the University of South Florida College of Medicine

We are deeply grateful to Dr. Donn L. Smith and all the contributing authors for bringing this special issue to our readers, commemorating the tenth anniversary of the matriculation of the Charter Class, and the opening of the University of South Florida College of Medicine. (See contents on opposite page.)

Editorial

- 695 The Journal Comes Full Circle

Departments

- 693 President's Page
A Tribute to the USF College of Medicine
Sanford A. Mullen, M.D.

- 701 Medical News Around the State

- 779 Correspondence

- 782 Information for Authors

- 783 Book Reviews

- 784 Meetings

- 787 Classified Advertising

- 790 Index to Advertisers

- 790 FMA Officers and Council Chairmen

Cover

The cover of this issue of The Journal commemorates the establishment of the University of South Florida College of Medicine, and the tenth anniversary of the matriculation of the Charter Class.

Special Issue

University of South Florida

College of Medicine

Table of Contents

Introduction	703
<i>Donn L. Smith, M.D., Ph.D.</i>	
The Birth of a Medical School, An Act of Creation	705
<i>Andor Szentivanyi, M.D.</i>	
First Ten Years	707
The Charter Class	714
The Charter Class, A Living Foundation	724
<i>Loren J. Bartels, M.D.</i>	
The Lady Speaks	727
<i>Patricia Barry, M.D.</i>	
A Student's Perspective	730
<i>Kenneth L. Schiffman</i>	
Admissions	733
The Student Body	736
Curriculum	738
Hospital Affiliations	744
Residency Training Programs	748
Surgical Residency at USF College of Medicine	750
<i>James A. Christensen, M.D.</i>	
Ph.D. Program in Basic Medical Sciences	752
The Mace	754
The Fulltime Faculty	756
The Change of Life at 50	758
<i>James M. Ingram, M.D.</i>	
Medical School Organization	761
Clinical (Volunteer) Faculty	762
Special Clinical Programs	763
Medical Library	768
Faculty Research	769
Continuing Medical Education	772
What of the Future?	775

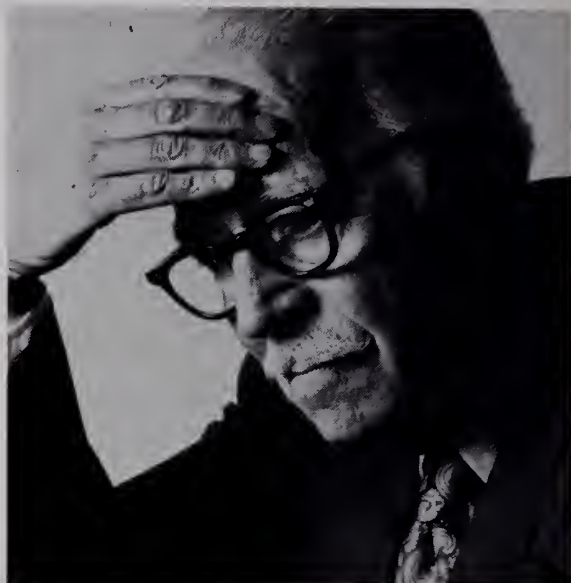
A TOTALLY NEW DELIVERY SYSTEM TO HELP REDUCE THE FEAR OF ANGINAL ATTACKS

Round-the-clock
protection with

ISO-BID

(ISOSORBIDE DINITRATE)

40 mg. capsules ... twice-a-day dosage



Controlled sustained release of ISO-BID's isosorbide dinitrate through micro-dialysis diffusion can help reduce frequency and intensity of anginal attacks. This in turn can minimize patient's fear of attacks, and dependence on nitroglycerin.

Unlike ordinary sustained release products, ISO-BID releases isosorbide dinitrate at a smooth, continuous, predictable, controlled rate to provide for up to 12 hours of therapeutic activity. Micro-dialysis is dependent only upon the presence of fluid in the G.I. tract and not on pH or other variables. ISO-BID is particularly advantageous in the prevention of nocturnal angina.

DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Some patients may require higher dosage levels. In these patients, dosage should be titrated, and they may require two ISO-BID capsules b.i.d. Not intended for sublingual use. Consult product brochure before prescribing.

THERAPEUTIC FOOTNOTE: IN TREATING ANGINA . . . FAILURES MAY RESULT FROM INADEQUATE DOSAGE. Reports in the literature indicate the usefulness of higher dosage levels of isosorbide dinitrate.^{1,3}

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

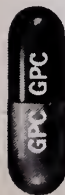
WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness

and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

SAMPLES AND LITERATURE AVAILABLE.



GERIATRIC PHARMACEUTICAL CORP. BOX 68. FLORAL PARK, NEW YORK 11001
PIONEERS IN GERIATRIC RESEARCH
DEVELOPERS AND SUPPLIERS OF CEVI-BID • GER-O-FOAM • TESTAND-B

1. Shane, S.J.: Canadian Family Physician. November 1973. 2. Lemberg, L.: Practical Cardiology. February 1976.
3. Abrams, J.: New England Journal of Medicine. May 29, 1980.





President's Page

A Tribute to USF College of Medicine

It is appropriate for the doctors of the Florida Medical Association to pause this month and pay special tribute to the University of South Florida College of Medicine. This issue of *The Journal of the Florida Medical Association* commemorates the tenth anniversary of the matriculation of the first medical students at USF. This third medical school in Florida was established following the 1965 action of the Florida Legislature which chartered a second state-supported college of medicine. For compelling reasons it was decided to place the medical school in Tampa as a part of the University of South Florida, an institution which itself had only been opened in 1960.

The series of articles in this issue of *The Journal* under the able guest editorship of Donn L. Smith, M.D., Ph.D., the charter Dean of the College, presents a graphic portrayal of the establishment of one of the most complex forms of educational institutions that our society has thus far produced. The articles portray the beginnings of this outstanding school from many points of view. They provide a fascinating insight into the complex problem of starting a new medical school.

The recognition of this fine medical educational institution provides an opportunity for comments on a subject that is of importance to all members of the Florida Medical Association. This important subject is the need for each member to recognize the value of practicing physicians being continually supportive of, and involved in, the Florida medical schools. At the same time it is equally important for the medical schools to recognize the need for a continuing close and harmonious contact with physicians in active practice.

Medical education in the United States has come a long way since the report, "Medical Education in the

United States and Canada," prepared for the Carnegie Foundation by Abraham Flexner in 1910. Prior to that report there had been a multi-class system of medical doctors practicing in this country. After the full impact of that report had been recognized by the medical education centers throughout the country, standards of education improved dramatically and a single class of medical practitioners with a uniform standard of excellence emerged. The country has now come to expect this high level of excellence in anyone who possesses the M.D. degree. There must never be a compromise of this standard which has meant so much to the health and well being of the people of the United States.

At the time of the Flexner report there was not even one medical school in Florida, a condition that existed for many years following the report. After World War II the need for the development of medical schools in Florida became obvious in a state growing as rapidly as Florida. Accordingly, the University of Miami School of Medicine was established in 1952 and the University of Florida College of Medicine was established in 1956. Those schools were recognized by special issues of *The Journal* in 1976 and 1980, commemorating the 20th anniversaries of their first graduating classes.

The existence of these three medical schools at a continuing level of excellence is of major importance to each practicing doctor in the State of Florida. Each doctor must work constantly to help these schools receive proper funding from the Florida Legislature and from other sources. The practicing doctor must be responsive to the needs of the schools and be supportive in every possible way. The practicing physician must help the medical school faculties in preparing physicians for the type of medical practice which exists in the non-academic

world. All would agree that the educators must have the final word in determining the precise details of medical education but they need regular input from practicing physicians in order to arrive at proper decisions.

An outstanding example of the cooperative efforts of practicing physicians and the medical schools in Florida has been the development of the program for continuing medical education sponsored by the FMA. This program has brought together the talents of academicians and practicing physicians in order to develop programs which assist physicians all over the State in maintaining current standards of excellent medical practice.

As the newest of our medical schools in Florida, USF graduates are just now beginning to become a part of the practicing community of physicians. Thus far their preparation and abilities have been found to be uniformly excellent. It seems certain that these high standards will continue by virtue of the quality of the students and the educational process to which they are subjected.

The major facility still needed at the University of South Florida College of Medicine is a teaching hospital which is completely under the control of the medical college. Although reports indicate that the relationships

of USF with the James A. Hailey Veterans Administration Hospital, the Tampa General Hospital, St. Joseph's Hospital, Women's Hospital, and the All Children's Hospital and Bayfront Medical Center in St. Petersburg are excellent, these institutions can never be an adequate substitute for a teaching hospital under the direct control of the medical school and located on its own campus. The existing relationships with these other institutions will continue to be important even after a teaching hospital is established, but the medical school controlled teaching hospital is absolutely essential in order to bring together the basic sciences and clinical medicine into a single cohesive program of medical education.

The first 10 years are the only beginning of an institution such as the University of South Florida College of Medicine. The magnificent strides that have already been made will appear to be quite limited indeed by the time the institution reaches the 20th, 30th, and 50th anniversaries of its existence. Congratulations are in order for all concerned with particular recognition of the role of Donn L. Smith, M.D., Ph.D., the charter Dean, who was the spark and the linchpin of the establishment of the University of South Florida College of Medicine.

Sanford A. Phyllis, M.D.

The Journal Comes Full Circle

With this issue, *The Journal* has come full circle, having published within the past five years a special issue devoted to each of the three medical schools situated within Florida.

The State's first medical school, the University of Miami, graduated its first students in 1956, and that event was appropriately commemorated 20 years later in these pages (October 1976). Four years later, as the University of Florida College of Medicine prepared to celebrate the 20th anniversary of the graduation of its first class, we paid similar homage.

The present issue, devoted to Tampa's University of South Florida College of Medicine, the youngest of the three schools, is tethered to a somewhat different landmark event — the matriculation of the first class.

Indeed, it was 10 years ago this very month that the charter class of 21 men and three women — Floridians all — first encountered the charter faculty which consisted of only four fulltime members.

Growth of the student body, faculty and the school itself; the development of the College's traditions; the forging of teaching agreements with Tampa area hospitals; construction of the College's physical plant; and the development of special clinical programs — all this and more are described in detail and in a manner that is bound to interest even the most casual and detached reader in the articles that follow.

One of the authors, Patricia Barry, M.D., shares with us her unique perspectives on the College over the last decade. Dr. Barry writes about the College as one who went to medical school there, as one who stayed on as a house officer, and as one who remains on the scene as a faculty member. (See *The Lady Speaks*, pp. 727)

Another interesting personal vignette is presented by James M. Ingram, M.D., who recalls how he was persuaded to leave his established private practice in the prime of his professional life to become the College's first

Professor and Chairman of Obstetrics and Gynecology. (See *The Change of Life* at 50, pp. 758)

Dr. Ingram recalls that he was attending an FMA Presidents and Secretaries Conference in Orlando in January of 1970 when founding Dean Donn L. Smith, M.D., invited him for some refreshments.

"Just after ordering, the Dean quietly and briefly invited me to become Chairman of the Department of Obstetrics and Gynecology," Dr. Ingram remembers. "I nearly fell off my stool, even though the refreshments had not yet arrived."

Dr. Smith's pitch to his prospective obstetrics and gynecology chief was typical of the determined and up-front manner in which he approached all his duties as Dean, characteristics that have made him virtually a legend in his own lifetime.

In a sense, Dr. Smith is the USF College of Medicine personified. As the founding Dean (the first of three men to hold that post), he got the College under way and guided it through its first crucial years. His primary purpose accomplished, Dr. Smith stepped down as Dean in 1976 to devote his full time to teaching and research.


Small wonder that when this special issue was suggested, the present Dean, the distinguished Andor Szentivanyi, M.D., turned to his venerable predecessor, handing him the task of getting it together.

As a Guest Editor, Dr. Smith has been a delight. He met his deadlines faithfully (an uncommon event in medical publishing) and met all his commitments. This issue is a monument to his considerable organizational talents. Therefore, it is appropriate that the present administrator has seen fit to dedicate the issue to the founding Dean and Guest Editor.

The editors of *The Journal* thank and congratulate Dean Szentivanyi, former Dean Smith and their colleagues for this valuable contribution to Florida's medical historical literature.



**When painful spasm
is the presenting
symptom...**



The illustration is a red-tinted anatomical drawing of the human digestive system. The esophagus, stomach, small intestine, and large intestine are depicted. Two human faces are superimposed on the organs: one on the stomach with a pained expression, and another on the large intestine with a look of surprise or shock. A circular graphic with a crosshair and a scale, resembling a medical measurement tool, is positioned over the lower part of the large intestine.

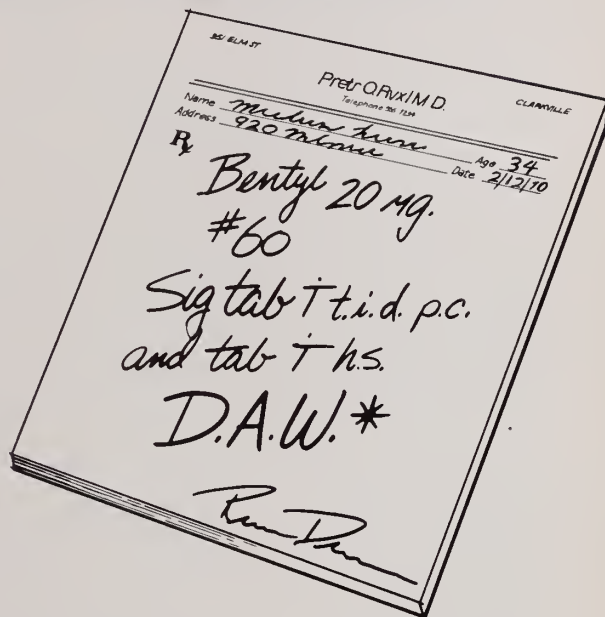


...in the functional bowel/irritable bowel syndrome*

be sure to specify

Bentyl[®]
(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



**D.A.W.-Dispense as written*

because:

- ⊕ The Bentyl molecule is a product of original Merrell research.
- ⊕ At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- ⊕ Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Significant pharmacologic effect in the distal colon compared to placebo,¹ shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

* This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:

1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, apnea, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by

CONNAUGHT LABORATORIES, INC.

Swiftwater, Pennsylvania 18370 or

TAYLOR PHARMACAL COMPANY

Ocatul, Illinois 62525 for

Merrell



MERRELL DOW PHARMACEUTICALS INC.
Subsidiary of The Dow Chemical Company
Cincinnati, OH 45215 U.S.A.

CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae*

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacterio. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemias, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults. †depending on severity

Wyeth Laboratories
Philadelphia, Pa 19101

SEPTEMBER MEANS SEAFOOD

And GREAT SEAFOOD means Florida's finest Stone Crab Claws . . .

End your summer the best way — healthfully, nutritiously, and deliciously — with the exotic seafoods from our own Florida waters.

Lobster Thermidor, Florida Lobster, Pompano Papillote, Swordfish Steaks, Jumbo Shrimp, and our special **Shore Dinners** — all of these delicious treats await you and your guests for the asking.

And, don't you have that impossible to buy for friend or relative? Well, how about the ultimate gourmet gift? That's right, SEAFOOD. Wouldn't you love to get Stone Crab Claws as a gift? Beats another tie, doesn't it?

Our fabulous seafood is Flash Frozen to ensure freshness, and ready for immediate heating and serving. We've done the preparation, all you have to do is ENJOY . . .

Of course, these Florida Delicacies are available all year long — but they really are at a premium right now.

Our Giant Stone Crab Claws come in five and ten pound paks —

Pak # 100: 5 lb. — Stone Crab Claws
Approx. 20 large, select claws \$53.50

Pak # 104: 10 lb. — Stone Crab Claws
Approx. 40 large, select claws \$79.75

Use the handy order form below, or contact your local Chairman or President, or write:

Mrs. David Whittaker
Florida Medical Association Auxiliary
1140 S.E. Fort King
Ocala, Florida 32670

Benefits go to the Florida Medical Foundation. Make checks payable to "FMA-Auxiliary — FMF".

All orders arrive in our own styrofoam container, which can be used again and again. All products are unconditionally guaranteed.

Name: _____

Address: _____

Phone No.: _____ Pak #: _____ Cost: _____

Gift card to read: _____

Please send a brochure: ☐



Edward J. Saltzman, M.D. . . . of Hollywood, has been named to chair the American Academy of Pediatrics' Provisional Committee on Practice and Ambulatory Medicine.

George A. Richard, M.D., of Gainesville was appointed to serve as a member of the Academy's Committee on Third Party Programs.

Two Florida physicians . . . have been selected for Fellowship in the American College of Radiology. **Rodney R. Million, M.D.**, of Gainesville, and **Lawrence R. Muroff, M.D.**, of Tampa, will be inducted into the College at the annual meeting of the ACR in Las Vegas, September 21-25.

The 54th Annual Meeting . . . of the Florida Hospital Association will feature a presentation on the Florida Medical Association and Florida Medical Foundation's Impaired Physicians Program.

Guy T. Selander, M.D., of Jacksonville, will discuss the FMA/FMF program for hospital administrators and other officials on Tuesday, November 17, at the Sheraton Twin Towers in Orlando.

Dr. Selander, Chairman of the FMF Committee on Impaired Physicians, will present the dramatic film, "Our Brother's Keeper", and discuss the role of hospitals in the program he oversees.

Eduard G. Friedrich Jr., M.D. . . . Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Florida College of Medicine has been appointed an associate examiner for the American Board of Obstetrics and Gynecology.

Darrell J. Mase, M.D. . . . Dean Emeritus of the UF College of Health Related Professions was presented with an honorary Doctor of Science by the College of Medicine and Dentistry of New Jersey recently. In addition, Dr. Mase will be honored by his alma mater, Emporia State University, as the recipient of a distinguished alumni award.

easy to take



Keflex®
cephalexin

Additional information available
to the profession on request.



Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

AT THE AMERICAN MEDICAL ASSOCIATION
WE'RE INVOLVED IN MEETING
THE IMPORTANT CHALLENGES AND
RESPONSIBILITIES OF THE 80's

This is another in a series of reports on major issues facing the medical profession. The purpose is to inform physicians and medical students on what the AMA is doing, on behalf of the profession and the public, to influence decisions that will affect health care in the next decade and beyond.

ESTABLISHING MEDICAL ETHICS FOR A CHANGING PROFESSION

As a physician or medical student, you automatically have a strong vested interest in medical ethics. Ethics are a traditional frame of reference for society's attitude toward physicians. Today in America, there is more reference to that frame than ever before.

That's because so many of today's health-care issues are ethical challenges. As outstanding examples, consider the moral right and wrong involved in:

- Seemingly excessive or needless costs of medical services—at a time when cost is the chief health-care issue and the chief basis for government intervention in care.
- Medicine's enhanced ability and obligation to prolong the lives of the terminally ill—versus pressures for mercy killing and for limits on the expenditure of health-care resources.
- Rules and procedures that could make medical records more accessible to outsiders. The moral conflict here is between the principles of confidentiality and the stake of third parties (notably government) in medical oversight and review.
- The question as to where various biomedical advances, such as genetic engineering and test-tube fertilization will lead us?

Those and similar questions involve the very character of

medical practice, including your own. Ethically wrong answers could distort that character.

Physicians have to do their best to provide answers that are both high-minded and sure-footed. Acting in concert, we have to come forth with sound ethical principles and applications.

The AMA has stood for traditional moral values from its very beginnings but has been flexible enough to keep adapting to new needs. In order to adapt, the AMA (by vote of its House of Delegates) revised its Principles of Medical Ethics last July—the fifth time it has done so.

Here are some of the ways in which the AMA has been applying medical ethics to relevant current issues . . . on your behalf:

- Stimulation of ways to cut down on needless or excessive health services and costs. This includes peer and utilization review, physician participation in PSROs, cost-benefit analysis, and alternatives to hospitalization whenever feasible.
- Model state legislation for disciplining the wayward or incompetent physician, who can be an economic as well as a medical problem. Twenty-three states now have laws that wholly or partially resemble the AMA model.
- New ethical standards on such topics as genetic engineering, test-tube fertilization, and euthanasia . . . as set forth in the latest edition of the AMA Judicial Council Opinions and Reports.
- Tireless legislative and legal efforts to protect the confidentiality of patient records.
- To maximize our effectiveness, we need YOUR MEMBERSHIP. The larger our membership (230,000 now), the bigger our influence. We need influence in coordinating the ethical commitment of American medicine . . . and in clarifying that commitment to government, to society, and throughout our profession.

We need YOU . . . if we're to give you all the help that you need.

For details on how to join, contact your state or county medical society or the Office of Membership Development, American Medical Association, 535 N. Dearborn, Chicago, IL 60610 (312) 751-6410.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

SEPTEMBER 1981
VOL 68 • NO. 9

Special Issue University of South Florida College of Medicine

**Guest Editor
Donn L. Smith, M.D., Ph.D.**

The University of South Florida College of Medicine is honored to have the privilege of presenting a special issue of *The Journal of the Florida Medical Association* to commemorate the 10th anniversary of the matriculation of the Charter Class.

The 10th year in the development of a medical college is an appropriate point at which to achieve some perspective of the complicated and very fast moving process which characterizes a successful new and developing College of Medicine. At the 10-year point there is no great weight of history sufficient to occlude appreciation of the present, nor to condition unduly a reasonably clear perception of the future in terms of what has gone before.

The accent remains clearly on the future progress of the enterprise, hope is yet a viable entity, and as yet, nothing appears to be impossible of accomplishment.

Our early graduates have completed their formal training programs, their performance has been assessed and we are aware of the relative efficiency of faculty efforts in teaching and providing role models. They have had the experience of learning in a student oriented environment, where they are considered as junior colleagues from the day of admission to the College.

Some of these young people, now newly in medical practice, will be known to a number of those who read this special issue. You may thus begin to judge this institution by its products. This is the most meaningful



Donn L. Smith, M.D., Ph.D.

Dr. Smith is Founding Dean and Professor, University of South Florida College of Medicine.

yardstick of institutional performance and will in time represent a fair portrait of the relative success of our endeavor.

The faculty is pleased that a large proportion of our graduates have entered the practice of medicine in Florida; a fact that helps to justify our existence. We all are prepared to assume the responsibility for the emergence of your young and new colleagues and sincerely hope that each of them will succeed in fairly earning your respect and appreciation.

Although in terms of a fully matured college of medicine, our history is brief, our aspirations for continued achievement and for the pursuit of excellence are continuing and growing with each passing year. The College of Medicine under the effective leadership of its impressive new Dean, Dr. Andor Szentivanyi, looks to the future with optimism. The complex and difficult nature of the problems which will face medical education in the next decade are recognized and solutions will be

developed. It is our sincere hope above all that our graduates will continue to become welcome and effective additions to the practicing community.

It is with sincere appreciation that I thank the Editorial Committee—Drs. Pierre J. Bouis, Julian J. Dwornik, James A. Hallock, Jack W. Hickman and Rudolf J. Noer—for their dedicated and generous gift of hard work and time expended in the preparation of this special issue, as well as my gratitude to the contributing authors. Special thanks are due to Mrs. Mary Gorman for staff and secretarial support, without which this issue could not have been possible.

Thanks are also due to the Editorial Staff of *The Journal of the Florida Medical Association*, Ms. Jennifer Teeter of the Learning Resource Center of the University of South Florida Medical Center and to Mrs. Nadine Evesson for word processing assistance.

Donn L. Smith, M.D., Ph.D.



The Birth of a Medical School— An Act of Creation

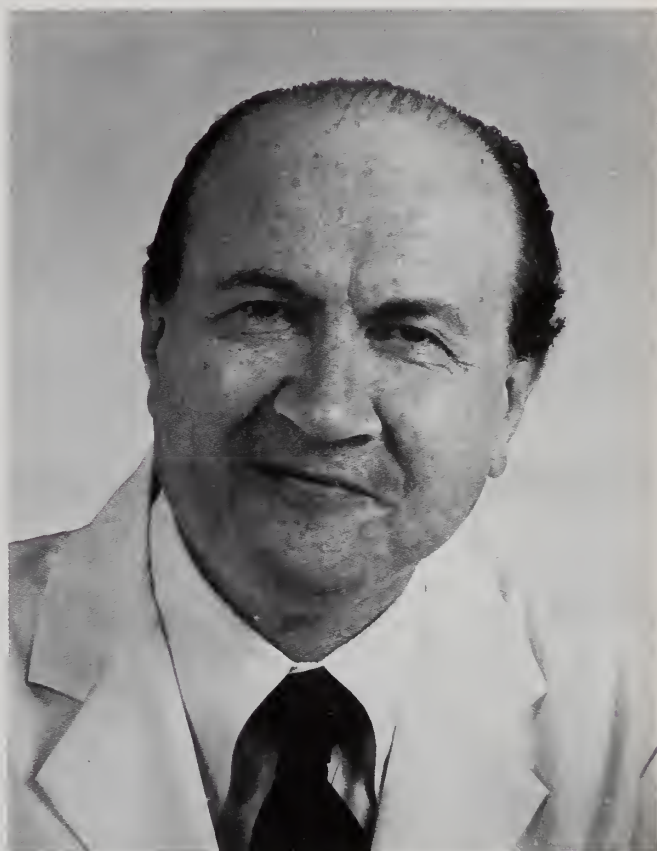
Andor Szentivanyi, M.D.

This special issue of *The Journal of the Florida Medical Association* describes and celebrates a fascinating act of creation, the act of creating a medical school virtually out of nowhere, without physical facilities, without faculty, without students, and in the face of an essentially unfavorable environment.

Above all, such an undertaking requires the leadership of an unusual person with extraordinary creativity. Comprehension of creativity is still beyond our reach. Nevertheless, most of the available major current works on the analysis of creative activities, i.e., the conscious and unconscious processes of scientific discovery, artistic originality, comic inspiration, or for that matter the creation of a new institution of higher learning, indicate a basic pattern in common revealing the inadequacy of mechanistic behaviorist theories in dealing with the problem of individual creativity. They offer in their stead, a formulation that relates functionally the mind and the personality, and concludes that it is a certain functioning of mind, a particular way of imagining, which is common to scientists, artists, and men with unusual gifts of creativity.

This is all the more important because the dominant trend of the past half a century of academic psychology has been to advance an assessment of man's condition that reduces him to the status of a conditioned automaton. This perception may be depressingly true, but only up to a point. The message of this anniversary issue on the development of the University of South Florida College of Medicine starts at the point where this argument ceases to be true. In this development, the point where the argument meets its boundary is the point where a man with extraordinary creativity, our founding Dean, Donn L. Smith, M.D., Ph.D., enters our scene.

The limited framework of this statement does not permit a detailed account of the many achievements of Dr. Smith. Instead, I would only mention that he is the only academician in the United States who has programmed, coordinated planning, planned, assisted in founding, and supervised construction of three academic



Andor Szentivanyi, M.D.

Andor Szentivanyi, M.D., is the newly installed Director of the Medical Center, and Dean of the University of South Florida College of Medicine. Dr. Szentivanyi received his medical education at the University Medical School, Debrecen, Hungary. Following postgraduate work at the University of Chicago, Dr. Szentivanyi embarked upon a distinguished career in research and medical education. He has authored a large number of scientific papers and has held the Chairs in Microbiology at the Creighton University School of Medicine and in Pharmacology and Therapeutics at USF.

health centers in our country, that is the Health Centers of the University of Colorado, the University of Louisville and the University of South Florida.

His significance in the history of our medical school, however, goes far beyond the traditional role of a founding dean. He represented an incomparable giant force driving the college toward goals which under the circumstances seemed to most mortals to be unattainable and which were almost as great as this extraordinary

man. His return to professorial interests left a vacuum that will never be filled because his creative gifts are irreplaceable. Nevertheless, he is with us and his presence provides not only a signal honor but also the reassuring continuity in the further development of our College of Medicine. Most appropriately, Dr. Smith is the Guest Editor of this Anniversary Issue which on behalf of our faculties of medicine and nursing is hereby dedicated to him.



The First Ten Years

The State of Florida has been the scene of a very rapid increase in population in recent years. The period 1960 to 1970 saw a gradually increasing rate of movement of large numbers of people to the State, with a parallel increase of tourism. By 1965, the State Government and the Legislature had become aware that a very large increase in the permanent population was underway which would ultimately exceed 9 million. Furthermore, it had become apparent that because of this expansion of population, Florida was in a debtor posture in the area of physician production. With two schools of medicine, one private and one public, producing only about 150 physicians annually it was clear that more physician manpower had to be produced within the State.

In response, the 1965 Florida Legislature chartered a second state-supported college of medicine. After a period of intense competition among several communities, it was decided that the new institution would be chartered to the developing University of South Florida at Tampa, which had opened in 1960 in a setting of extremely rapid urban growth. The Tampa Bay area encompasses five counties that in 1965 had an aggregate population of about 1.5 million; by July 1, 1976, the population had grown to some 2.5 million. The selection of the site for the new college of medicine on the populous west coast of Florida, in the center of the state, was a

natural result of the presence of the University of Florida College of Medicine in Gainesville in the north, and the University of Miami Medical School to the south.

This account records the history of the University of South Florida College of Medicine from 1970 to 1980.

During the period January 1, 1970 to January 1, 1976, construction of the college was completed, and all of the projected physical facilities were in place and occupied.

The programmed yearly admission of 96 students was achieved, and faculty and staff to support the maximum enrollment were present. During that period, intense programming, staff and faculty recruiting, fiscal planning, and organizational planning were accomplished. Early in the process, initial, medium, and long-term objectives were set to serve as guidelines within which the development of the new school would occur. By January, 1976, all of the initial objectives set forth in 1970 had been met, and progress toward achievement of long-term goals was underway.

The definitive planning process began on January 1, 1970 with the arrival of a full-time dean and the appointment of a business manager for the medical center.

The first step was to construct a program to include all the essential elements of a fully operational college of medicine. The number of students, faculty and staff, operating budgets, and the size and conformation of the physical facility were all projected and coordinated on a year-by-year basis for a 10-year period beginning in 1970. A "letter of reasonable assurance" from the Liaison Committee on Medical Education awarded on June 22, 1970 represented a major step forward. The letter represented the opinion of the Liaison Committee on Medical Education that there was reasonable assurance the school would meet full accreditation requirements by the time the first class was to graduate.

Projected Schedule

Projected schedules and programs were approved by the Board of Regents and the Legislature in the late spring of 1970, and planning proceeded rapidly. The



University of South Florida
College of Medicine

matriculation of the charter class of 24 students was set for September, 1971. Construction was to begin in March, 1972, pending a successful application for matching federal funds.

Initially, construction costs were budgeted for two phases. Plans called for overlapping construction of the two phases, so that Phase II construction would be well underway before Phase I was completed. Construction of Phase III, a university hospital, was placed in abeyance until the completion of Phase I and II, which were to become a unified complex of structures, interconnected and functionally one building.

The projected number of faculty and support personnel, building size and space arrangements, parking spaces, and budget projections were all computed around the central issue of the ultimate size of the student body. A class of 96 students appeared to provide the greatest degree of cost-effectiveness in terms of the desired level of educational excellence and a realistic assessment of attainable funding for both construction and annual operations. The plans that evolved for the total facility were accepted by the University, the Board of Regents, and the State Government and were ultimately financed from combined state and federal funds.

Construction Completed

Construction began in March, 1972, and the entire project was completed in January, 1976. The structure contained: facilities for the basic sciences, student and teaching areas, cafeteria, medical library, clinical sciences, continuing education, ambulatory care, and vivarium. Spatial arrangements and content of Phases I and II revolved around the student body size and the projected numbers of faculty and staff, to a total of 383,368 square

feet. The entire facility is fully interconnected and there are no separate buildings in the usual sense. Full occupancy, which occurred in January, 1976, has proven the design to be highly satisfactory. No major construction faults have developed nor have any sizable renovations been necessary. Maintenance has been easy and convenient in the double-center-chase, interior-exterior type of design in which all utilities are concentrated centrally, both horizontally and vertically. Future changes may be accomplished without significant disruption of ongoing activities.

Student Selection

The student selection process, as in most medical schools, is a difficult and time-consuming process. Because of Florida's rapid and large population growth, by 1975 an applicant pool of more than 1,000 state residents had developed, which now provides most of the students in the three medical schools in the State, as well as over 95% of the medical students of this institution. Many of the State residents who matriculate have attended out-of-state universities and thus have brought to the College a wide variety of cultural and educational backgrounds. This eases to some degree any danger of the development of provincialism, which is a concern when accepting a large proportion of in-state applicants. (See article on Admissions.)

Provisional Accreditation

Provisional accreditation and permission to enroll a charter class of 24 students were granted on July 16, 1971. The first students were selected from some 400 applicants. This relatively small number of applicants was apparently due to the rather sudden emergence of the



First survey stake on site (left) and construction begins (right).

school from a widely held "lost-cause" posture, and because of an understandable reluctance on the part of some potentially successful applicants to risk the vagaries of an untried enterprise. In addition, it was well known that only 24 seats were available and that competition would be severe.

This class, then, was selected at a rate of one admission per nineteen applicants. It was an outstanding group of courageous young people who have done well in house staff positions at academic medical centers across the country. Most are now active in a variety of professional pursuits, in the State of Florida. The growth of entering class sizes has been accomplished with careful consideration for space and faculty resources, plus increased fiscal support. Admission of 96 students a year began in July, 1976, and continues at that level.

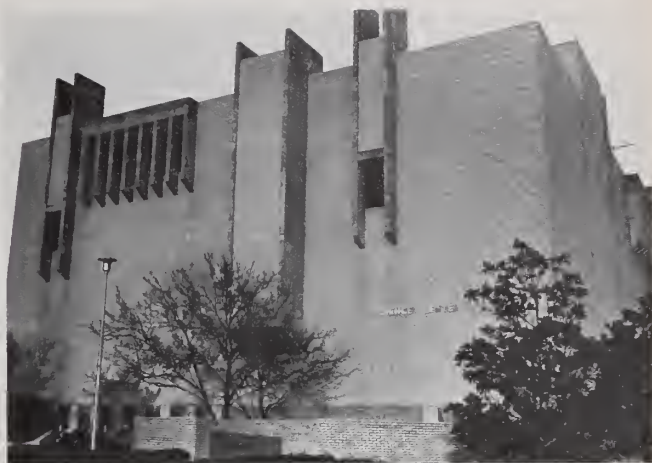
The faculty will long remember with pleasure the small class environment. From an intellectual point of view, it is unfortunate that cost-effectiveness and political pressures operating in modern medical education allow for only temporary exposure to this type of experience.

Early in the development of the school the student body designed its own honor code and a system of governance, neither of which has required administrative or faculty intervention in the years since.

The primary objective in faculty recruitment was to obtain basic science faculty who were both excellent teachers and accomplished investigators and clinicians for whom interest and proficiency in teaching as well as demonstrated clinical expertise were major criteria. A respectable research effort was expected from members of the clinical departments, but it was recognized that additional specialized personnel with appropriate research backgrounds would be required in those departments.

The basic science chairmen were acquired first, and they in turn recruited the departmental faculty on a programmed basis. Because of the desire to arrange for early exposure to clinical material, arrival of the clinical chiefs was scheduled prior to the matriculation of the charter class. The clinical chiefs then recruited the necessary personnel on a programmed basis coordinated with space and budget projections.

During the 1972-73 academic year, construction of the 720-bed Veterans Administration Hospital adjacent to the Medical Center was nearing completion so it was possible to arrange for research and teaching space to be made available well before construction of the medical center was completed. By arrangement with the VA and the County Board of Health and Welfare, all the school's clinical departments were fully housed either at the VA Hospital or Tampa General Hospital, and were functional prior to the beginning of clinical teaching. As a result the hiring of faculty for the clinical departments was



**Science Center
Initial Temporary Quarters**

maintained at a level very close to that projected.

The faculty that came to the college was basically a young somewhat inexperienced group, led by mature and able departmental chairmen dedicated to the solution of the many problems incident to the establishment of a sound teaching program.

College and University Relationships

From the beginning, the relationship between the Medical College and the University was unique in that the University was relatively new, rapidly growing, and not particularly disposed toward professional graduate-level education. The Founding President was a well-recognized scholar who had been Vice-President at another university during the organization of a new medical school. He was fully aware of the political and economic pressures of the 1960's that led to the decision to establish new medical schools, fix their location, and create requirements for appropriate funding. Many nonacademic people in the community felt the University should accept with enthusiasm a new, expensive, and complex educational program — an opinion about which certain reservations were held by some academicians within the University.

Over the period of several years, the understandable initial fears of the University Faculty and Administration that the university budget would be depleted in order to support medical education have been laid to rest. It is now known and accepted that the medical center must prepare separate application for financial support, and that its financial needs have no implications for the university's general budget. The constraints surrounding the sharing of resources are also fairly widely understood.

The initial administrative arrangements with the



**Surge Building 1971
Additional Lecture Room and Lab Completed
for Arrival of Second Class.**

University were placed on a sound and practical basis. The Director of the Medical Center, who was also Dean of the College of Medicine, reported directly to the President. Medical Center requests and operating budgets were fully under the control of the Dean subject to approval by the President and the Board of Regents.

Medical college faculty have served with distinction on university-wide committees and in the University Senate. While the passage of time and a closer relationship with Medical Faculty have greatly reassured many University Faculty, a major concern is the salary differentials and the obvious capability of the medical faculty to generate additional income. There appears to be no way to alleviate the very human reaction to that situation. An increasing amount of quality and much appreciated medical care rendered to the university community is, however, providing a new dimension of mutual respect.

The myriad tasks and obligations that face those responsible for establishing a new school of medicine present a wide spectrum of challenging problems. A major concern involves the establishment of relationships with community agencies and organized medicine. The geographic setting, cultural and socioeconomic conditions, as well as the size and history of the community, are major determinants that bear on the magnitude and characteristics of the problem.

In Tampa, the situation was complicated by a sudden and dramatic influx of large numbers of people to the area to take up permanent residence. The emergence of a state university with a student body that quickly grew to almost 25,000 in the formative years of the medical school was an additional complication that affected University-community relations—and it was one that the Medical School inevitably shared. Thus a rapidly growing and changing community, together with an equally rapid growth in the size of the University, placed the medical

school at a complex, three-faceted interface with the university, the community, and the local medical profession. An initial survey of the situation clearly showed that the medical school must advance and cement many governmental and community relationships at a fast rate and in an effective manner.

Community Relationships

Affiliation agreements with two major community hospitals were consummated without significant difficulty and approved by all of the governing bodies concerned. Early and harmonious dialogue was initiated with the active voluntary health agencies, particularly the county and state heart and cancer societies, and a very beneficial connection was made with the Gulf Coast Pulmonary Group.

The benefits derived from these relationships have been many, and continued associations with these groups seems assured. The productive nature of these relationships is nicely exemplified by the award to the College of Medicine of the first Endowed Chair in the university, through the good offices of the Suncoast Heart Association.

The relationship of the College with state agencies has been quite productive.

An excellent liaison has been established with the Children's Bureau of the State Health and Rehabilitation Services Department. The College has become involved in a number of agency programs concerned with neonatal intensive care, juvenile diabetes, and heart disease. These advances have been made possible by the effective activities of the Chairman of Pediatrics, who has worked long and hard to establish good community relations. The Department of Medicine has established a diabetes center in cooperation with the state.

On the whole, the medical community at the local level has been supportive, understanding, and kind. Many of the college's clinical faculty are participating members of the Hillsborough County Medical Association, serve on its committees, and are accepted by the medical community. Local specialty organizations are also supportive and make considerable contributions to the teaching program. Relationships with organized medicine, more specifically with the Florida Medical Association have been excellent.

Affiliation Agreements

The decision to defer Phase III, the Teaching Hospital, until completion of Phases I and II made it clear that affiliation with local institutions would be essential.

Though a University Hospital was to be developed in the future, it was clear that a close affiliation must be established with at least one major community hospital,

in addition to the new VA Hospital then under construction. The clinical teaching needs for classes of 96 students will always require the participation of at least one or two community hospitals, even after the acquisition of the University Hospital.

Tampa General Hospital was obviously a choice as it was a full service institution of about 600 beds with some house staff programs in operation. A second major hospital was St. Joseph's Infirmary, a new, full-service institution of approximately 440 beds. Tampa General is a combination public and private institution; St. Joseph's is a fully private institution. Negotiations with both hospitals were instituted early in 1970 and affiliation agreements achieved late in the spring of that year.

The affiliation agreement with Tampa General Hospital was negotiated by the Dean of Medicine, representatives of the hospital medical staff, and the hospital administration. A major problem in the negotiations concerned the separation of medical education from areas of private practice within the hospital, because a number of the medical staff preferred not to engage in teaching activities. It seemed reasonable that these physicians and their patients should not be forced into the educational process. The primary difficulty was to determine how house staff service could relate to this category of physician and patient. The issue was ultimately resolved by agreement that house staff service to this group would be rendered in emergency circumstances and life-threatening situations. It was also agreed that medical school faculty would be members of the hospital staff and subject to its bylaws, and that private practitioners would be admitted to faculty status upon approval by the College of Medicine.

In addition, the College agreed to undertake the medical care of all indigent patients admitted to the hospital or its outpatient clinics. As members of the hospital medical staff, medical faculty would be entitled to admit their private patients to the hospital.

The affiliation with St. Joseph's Infirmary was negotiated in a similar manner and in the same time period, but was somewhat different in structure because of the private status of the hospital, and the type of practitioner in the institution. An important part of this agreement gave the medical school control over the operation of a community mental health facility located in the hospital. In addition, a stated number of beds were made continually available for the patients of full-time medical faculty. Otherwise the affiliation is comparable to that executed with Tampa General Hospital.

Other affiliation agreements formulated and implemented on a departmental basis include a pediatric residency program at All Children's Hospital and as the size of the entering classes was increased, affiliations for the conduct of obstetrical residencies were consummated

with Women's Hospital of Tampa and the Bayfront Medical Center in St. Petersburg.

The Tampa VA Hospital, as a "Dean's Committee" hospital, represents a major teaching asset. Medical education there is conducted at the university hospital level in internal medicine, surgery, pathology, psychiatry, ophthalmology, and radiology. Pediatrics and obstetrics and gynecology must depend on the other affiliations, although a fairly active gynecological consultation service for ex-servicewomen has been developed at the VA hospital.

The coordination and management of this fairly complex network of hospital affiliations is time-consuming, but the overall value and cost-effectiveness of these arrangements has been well worth the effort. The wide variety of clinical exposures and the substantial number of different approaches to patient care are of great benefit to both students and house staff as they rotate through the respective hospitals and services.

Residency Programs

All residency programs are fully integrated and under the complete control of the departmental chairmen, which is a major benefit for the hospitals concerned and for the College of Medicine. In a relatively short period of time most of the residency programs have become oversubscribed, with a resultant and very visible upgrading of program quality. Thus the College from the beginning became deeply involved in the community and its health care activities.

Responsibility for the creation and academic development of a modern medical center elicits a deep, almost total, intellectual and emotional involvement. The continuous expenditure of time and effort required to achieve full operation of such an enterprise may result in an appreciable loss of perspective which is not conducive to a fully objective assessment of success or failure.

Some specific elements of the growth and development of the College do provide, however, a reasonably clear basis for judgment and retrospective comments concerning variable degrees of success, even though no complete success or total failure is apparent as yet in any particular area of endeavor.

The physical facilities are functional, attractive aesthetically and represent a reasonable return on the funds invested. Maintenance costs are low, and the facilities afford the occupants a comfortable, but not lush, environment. No significant expenditures for changes in the facilities have been necessary. There is a general agreement that the medical library represents a highly successful design and is very appropriate to the specific functions of the facility.

The level of financial support made available to the institution via a budget handled on a special unit basis by



Plaza Student Area

the legislature has been most gratifying.

Student Faculty Relations

The College of Medicine has attracted a conscientious, hardworking student body. Harmonious relationships between students and faculty have existed from the beginning. Mutual respect and tolerance exist between

students. Perceptible esprit in the enterprise is engendered by the strength of these relationships.

The young and vigorous faculty demonstrate enthusiasm and obvious competence.

The full programmed enrollment has been achieved without significant dilution of the educational effort and provides a valid yardstick for the measurement of the accuracy of the initial program projections.

Although good fortune and some careful adjustments have allowed the institution to avoid total failure in any of its operations, there are nevertheless some areas of activity where better results could have been achieved. Some misalignment of priorities, occasional hasty action, and a pressing need to create and maintain momentum in the face of the inevitable unforeseen obstacles and crises have led to some less than perfect outcomes.

The Medical College was structured in classical mode and no great effort was made to introduce innovations. There was, rather, a careful review made of those characteristics of medical education that have proved successful, and they were adopted. An equal effort was made to exclude those aspects of medical



First Commencement, 1974



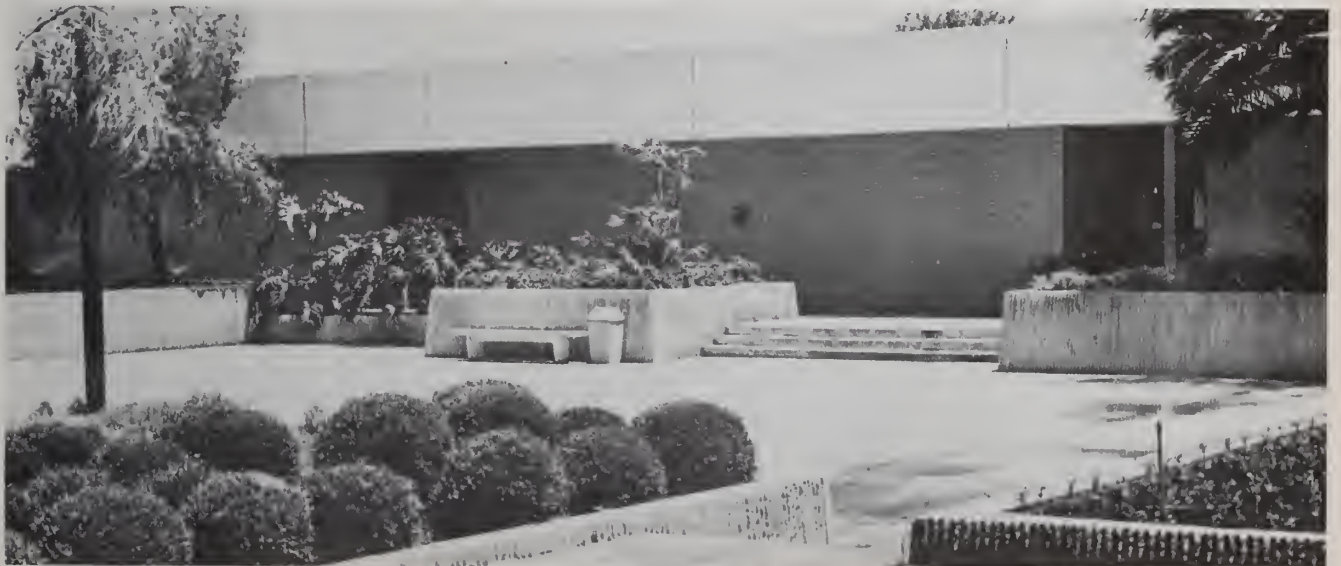
Dedication of the Medical Center by Governor Askew, 1976

education that have proven to be undesirable.

A flexible attitude and competent institutional self-evaluation should provide the stimulus for healthy change when appropriate. The faculty came to us from many other institutions, and thus brought with them the fruits of their previous experience and training. An effective melding of the numerous and sometimes diverse approaches to education and patient care in itself creates a new enterprise with its own unique character.

Innovation is thus difficult to attain, and attempts to enforce new approaches may result in the introduction of change for its own sake, or induce imitative modes that may delay progress toward excellence.

The wisdom of this approach will probably be adequately tested and either justified, or found wanting, at least in part, during further maturation of the institution.



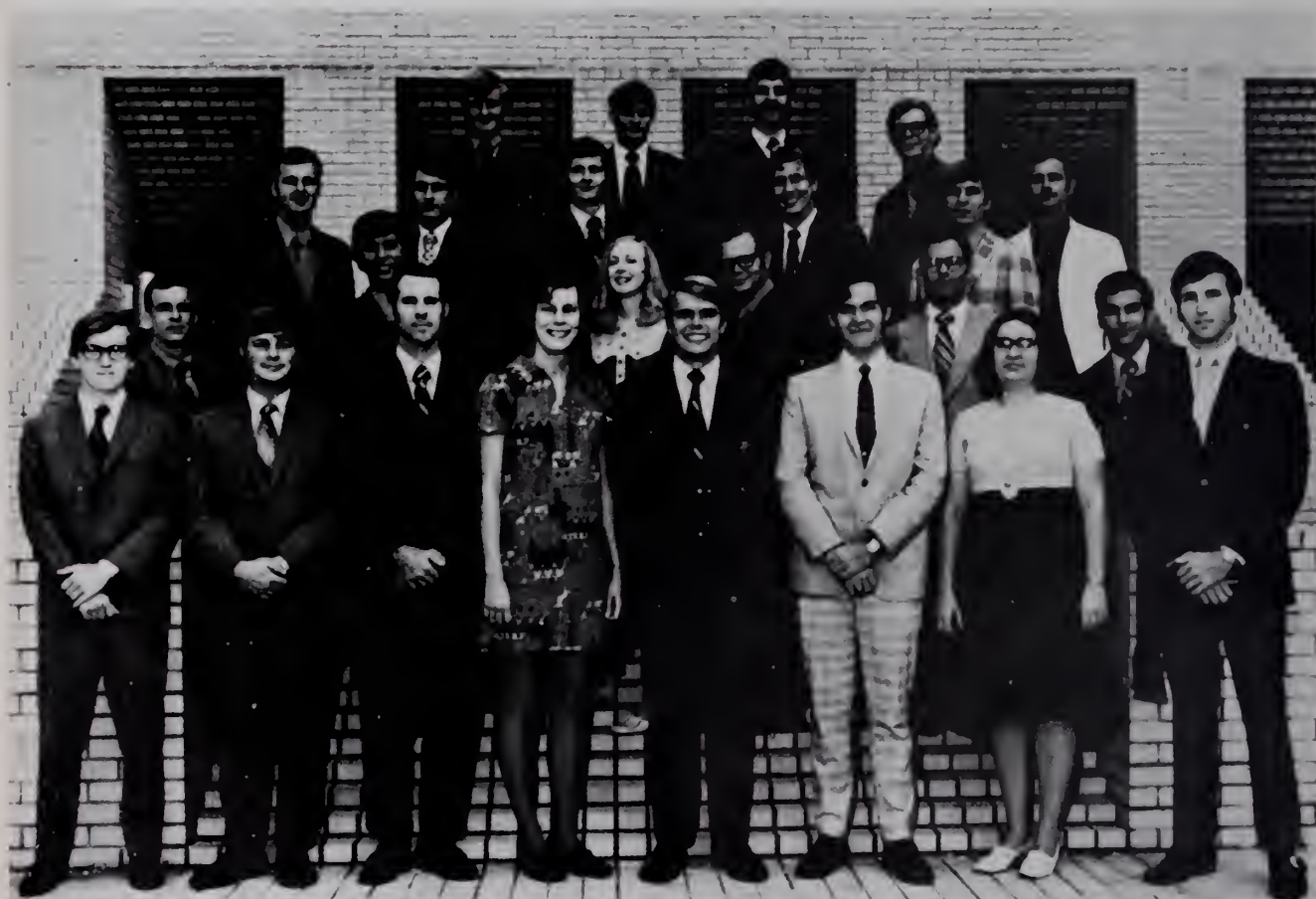
The Charter Class

Members of the University of South Florida, College of Medicine's Charter Class were selected by the faculty using standard criteria including scholastic achievement, Medical College Admission Test scores, premedical faculty letters of recommendation, extracurricular activities and personal interviews.

As the first faculty members arrived during the summer of 1970, so did a veritable deluge of completed applications for admission, grade transcripts and letters of recommendation. The admissions application forms had been constructed using a process of liberal

plagiarism from the forms used by existing medical schools.

Any thoughts that this new College of Medicine might quietly open its doors unnoticed quickly vanished as just over 400 completed applications were received for the initial 24 places. The Committee on Admissions was easily formed; all 10 fulltime faculty members were appointed, as they were to all other committees. Some initial interviews could have been described as "unstructured" in that they were the first interview for both the candidate and the faculty member who was conducting it.



The Charter Class

The Selection Process

The selection process proceeded quite well, however. The 24 entering students had competitive grade point averages. The faculty, from the beginning, was willing to look at a number of factors other than test scores and grade point averages in selecting the first class. This has been proven to be productive in view of the fine performance of many of the graduates of this school who have demonstrated humanistic and other qualities that have helped to make them excellent practitioners.

If the prospective student was not impressed by the size of the Charter Faculty, he certainly could not have been overwhelmed by the physical facilities at that time either. A member of that class has given a fine description of the "physical plant" in another article in this issue.

A special degree of courage was shown by the 24 members of the Charter Class who matriculated in September 1971. Most had received acceptances at other medical schools, yet they were willing to cast their lot with the new faculty by then grown to 24, in cramped surroundings at a College of Medicine with no past record of excellence, but merely a Letter of Reasonable

Assurance from the Association of American Medical Colleges, on which to proceed.

Female Students

The students' home towns ranged from Goldenrod, Florida to Palm Beach Shores, Florida and their premedical backgrounds were equally diverse. All were residents of the State of Florida. At that time we were quite pleased that three women were in the class. That percentage, 12.5% has more than doubled to 29.2% in 1980, in the decade that has followed.

Following are photographs of members of the Charter Class and information as to their present location and type of practice. The faculty takes pride in each graduate of the University of South Florida College of Medicine. Since there can be but one Charter Class, the faculty, particularly the early faculty, will always have a warm spot in their hearts for each member of that historic group of fine young medical students.

We present with pride and respect the members of the Charter Class.



Karl M. Altenburger, M.D.

National Jewish Hospital and Research Center
3800 East Colfax Ave., Denver, CO 80206

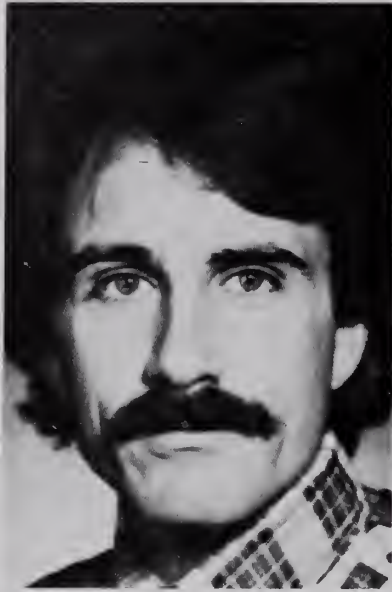
Pediatric Allergy/Immunology - Fellowship -
Miami High; Premed at University of South Florida. Residency training at University of Colorado Medical Center, 1975-1978. Membership in American Academy of Allergy, American Thoracic Society, and American Academy of Pediatrics.



Rufus S. Armstrong, M.D.

2123 W. Buffalo, Tampa, FL 33607

Obstetrics/Gynecology - Private Practice -
Auburn High School; Premed at Auburn University. Residency training at University of South Florida Affiliated Hospitals, 1975-1978. Received the Robert G. Nelson Award. Membership in Florida OB-GYN Society, Board certified, ACOG.



Douglas J. Barrett, M.D.

J-296, JHMHC, University of Florida, College of Medicine, Gainesville, FL 32610

Pediatric Immunology - Assistant Professor -

Largo High School; Premed at University of South Florida. Residency training at Upstate Medical Center, Syracuse, N.Y. 1975-1979. Fellowship at University of California at Los Angeles, 1979-80. Received the R.G. Thompson Research Fellowship, American Cancer Society, Florida Division Mosby Scholarship Award, John Hartford Foundation Fellowship Training Grant, and Assistant Research Immunologist Support Award - NIH, Membership in American Academy of Pediatrics, Southern Society for Pediatric Research, Florida Medical Association, Alachua County Medical Society.

Loren J. Bartels, M.D.

USF - College of Medicine, 12901 North 30th St., Tampa, FL 33612

Otolaryngology - Assistant Professor - H. B.

Plant High; Premed at University of South Florida. Residency training at Geisinger Medical Center, Danville, PA 1975-1979. Fellowship Otolaryngology, Neurotology; Otologic Medical Group and Ear Research Institute in Los Angeles. Received the University of South Florida College of Medicine Physiology Award. Membership in Phi Kappa Phi, Pi Mu Epsilon, Alpha Omega Alpha and Omicron Delta Kappa.



Lindsay Struthers Bell, M.D.

2323 1st Avenue North, St. Petersburg, FL 33713

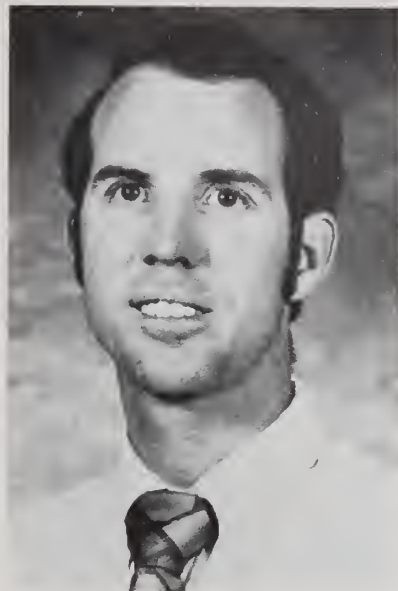
Gynecology - Private Practice - Robert E. Lee

High School; Premed at University of Richmond. Residency training at University of South Florida Affiliated Hospitals, 1975-1978.

Thomas G. Bell, M.D.

234 Beach Dr. N. E., St. Petersburg, FL 33701

Ophthalmology - Private Practice - Northeast High School; Premed at University of Florida. Residency Training at University of South Florida Affiliated Hospitals, 1975-1978. Active in Rotary Club.



Grant P. Carmichael, Jr., M.D.

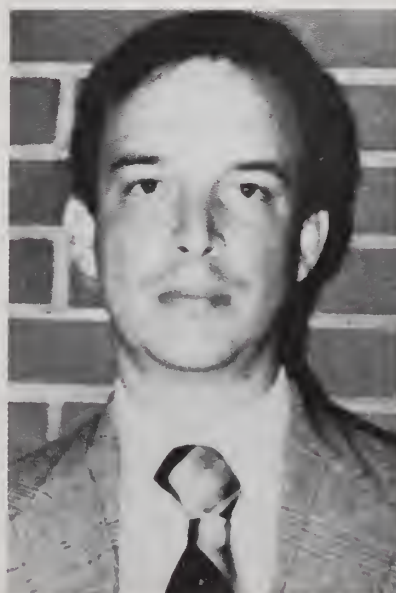
612 Fairfield Dr., Merced, CA 95340

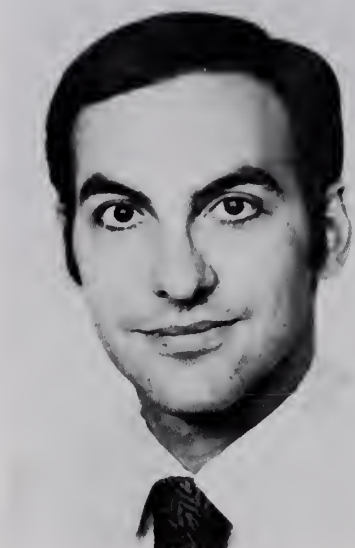
Pathology - Private Practice - Hardee County High School; Premed at University of Florida. Residency training at University of South Florida Affiliated Hospitals, and University of California Los Angeles Medical Center, 1975-1979. Received Pathology and Neurology Awards, University of South Florida College of Medicine 1974.

Malcolm D. Clayton, III, M.D.

US Naval Hospital, Beaufort, SC 29902

Internal Medicine - Lt. Commander, US Navy - King High School; Premed at Emory University. Residency training at NRMHC Portsmouth, Portsmouth, VA., 1977-1980. Diplomate American Board Internal Medicine.





John W. Demetree, M.D.

5857-A 21st Ave. W., Bradenton, FL 33529

Dermatology - Private Practice - Edgewater High School; Premed at Emory University. Residency training at Tallahassee Memorial Hospital - Dermatology 1975, University of Pittsburgh and Emory University, 1976-1978. Received Emory University Dermatology Resident Research Award, Chief Resident in Dermatology, Emory University.

Joseph F. Dibble, II, M.D.

1952 49th Street So., St. Petersburg, FL 33707

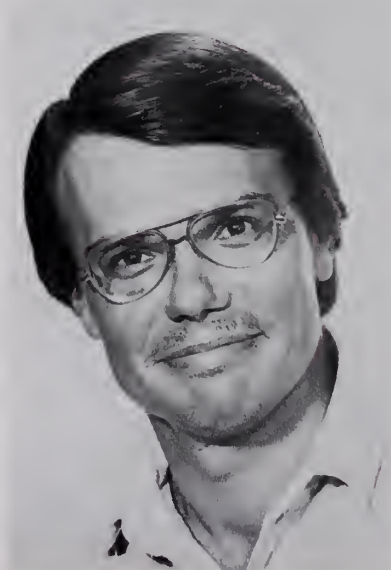
Family Practice - Private Practice - Hardee County High School; Premed at University of South Florida. Residency training at Bayfront Medical Center, St. Petersburg, FL., 1975-1977. Awarded a full medical school tuition scholarship. Membership in Phi Kappa Phi; Diplomate American Board of Family Practice and Director of Eckerd College Health Center 1977-78.



Gary L. Dunlap, M.D.

132 Manatee Avenue East, Bradenton, FL 33508

Orthopaedic Surgery - Private Practice - Key West High School; Premed at The Citadel. Residency training at University of South Florida Affiliated Hospitals, 1974-1979. Listed in Who's Who in American College and Universities, 1970.



John M. Elliott, M.D.

1201 N.W. 64th Terrace, Gainesville, FL 32601

Radiology - Private Practice - Whitesburg High School; Premed at University of Central Florida. Residency training at University of South Florida Affiliated Hospitals, 1976-1980.



Sheila F. Farmer, M.D.

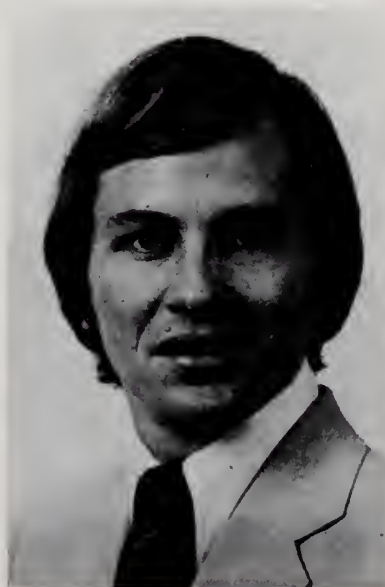
601 Florida Ave., Tampa, FL 33602

Internal Medicine - Lt. Commander - USPHS H. B. Plant High School; Premed at University of South Florida. Residency training at St. Francis Hospital, Hartford, CT, 1975-1978. R. G. Thompson Cancer Research Fellowship - American Cancer Society. A member of the American College of Physicians.

John M. Hellrung, M.D.

720 S.W. 2nd Ave., Gainesville, FL 32601

Pediatrics - Private Practice - Clearwater High School; Premed at University of Florida. Residency training at University of South Florida Affiliated Hospitals, - 1975, University of Florida, 1978-1979. A member of the Big Brothers of America.





Russell W. Jenna, Jr., M.D.

R. W. Bliss Army Hospital, Ft. Huachuca, AZ 85613

Radiology - Lt. Colonel - U.S. Army - Chief, Department of Radiology. Seoul American High School; Premed at U.S. Military Academy. Residency training at Brooke Army Medical Center, San Antonio, TX, 1975-1979. Medical Consultant at Cochise County Health Department, Sierra Vista, AZ.

Robert Martinez, M.D.

402 W. Buffalo Ave., Tampa, FL 33603

Neurology - Private Practice - H.B. Plant High School; Premed at University of South Florida. Residency at University of South Florida Affiliated Hospitals, 1975-1976 and at Medical University of South Carolina, 1976-1978. Chief Resident 1977-1978.



Luther M. Mceachern, M.D.

Lake Charles Medical & Surgical Clinic
1801 Oak Park Blvd., Lake Charles, LA 70601

Cardiology - Private Practice - H.B. Plant High School; Premed at University of Mississippi. Residency training at University of South Florida Affiliated Hospitals, 1975-1977. Cardiology Fellowship at University of South Florida, 1977-1979. Received Laennec Award for excellence in clinical medicine, Deans Award, Membership in Alpha Omega Alpha and currently engaged in drug research. A member of the Louisiana Chapter of American Heart Association and a member of the clinical faculty at Louisiana State University.

William D. Parker, Jr., M.D.

University of Colorado Medical Center, 4200 E. 9th Ave.,
Denver, CO 80220

Pediatric Neurology/General Neurology - Assistant Professor - Sarasota High School; Premed at John Hopkins University. Residency training at University of South Florida and University of Virginia, 1975-1980. Awarded Fellowship - Neurology (Genetics) University of Virginia 1980-1981.



Gary G. Peterson, M.D.

New Mexico School of Medicine
Children's Psychiatric Center, 1001 Yale, Albuquerque,
New Mexico 87131

Child Psychiatry - Assistant Professor - Seabreeze High School; Premed at U.S. Air Force Academy and University of Florida. Residency training at University of Oregon, and University of California at Los Angeles, 1975-1979. Honored as one of the Outstanding Young Men of America - 1980. Membership in Eta Kappa Nu.

Gregory J. Piacente, M.D.

University of Pennsylvania, Pennsylvania Hospital, 8th
and Spruce Sts., Philadelphia, PA 19107

Behavioral Neurology - Clinical Assistant Professor - Boca Ciega High School; Premed at Emory University. Residency training at Presbyterian Hospital, University of Pennsylvania Medical Center, and Pennsylvania Hospital, 1975-1980. Honored by National Hospital, Queens Square, London 1978. Membership in American College of Physicians and Alpha Omega Alpha.





Caroline Setzer Rains, M.D.

Wedco District Public Health
200 Professional Ave. Winchester, KY 40391

Public Health - Staff Physician - Academy of the Holy Names; Premed at the University of Florida and the University of South Florida. Residency training at University of Kentucky, 1975-1977. Received the Upjohn Award in Immunology and Charles Collins Award in OB/GYN. Membership in Alpha Omega Alpha.

Stephen E. Vernon, M.D.

250 W. 63rd St., Miami Beach, FL 33141

Anatomic and Clinical Pathology - Private Practice - Santa Fe High School; Premed at the University of South Florida. Residency training at University of South Florida Affiliated Hospitals, and University of California at Los Angeles Hospitals and Clinics, 1976-1979. Clinical Fellowship - American Cancer Society 1978-1979; Member of Florida Society of Pathologists, American Society of Clinical Pathologists, and American Medical Association. Volunteer instructor at Miami Dade Community College.



Joseph G. Wheeler, III, M.D.

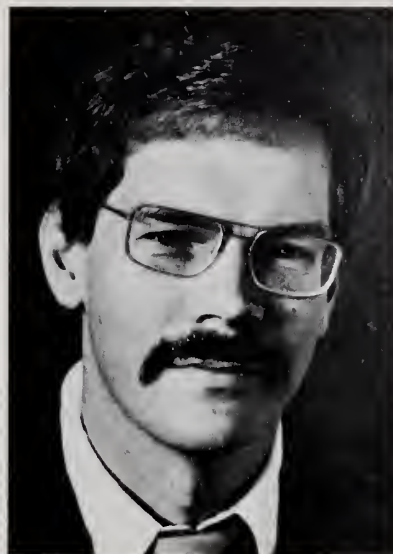
USF College of Medicine
12901 N. 30th St., Tampa, FL 33612

General Surgery - Assistant Professor of Surgery - Admiral Farragut Academy; Premed at University of Florida. Residency training at University of South Florida Affiliated Hospitals, 1975-1980.

Gary E. Winchester, M.D.

1541 Medical Dr. Suite 215-B,
Tallahassee, FL 32308

Family Practice - Private Practice - Leon High School; Premed at University of Florida. Residency training at Tallahassee Memorial Hospital, 1975-1977; Chief Resident, Family Practice Residency third year. A Fellow of the American Academy of Family Practice.



The Charter Class, a Living Foundation

Loren J. Bartels, M.D.

The 10th anniversary since the matriculation of the Charter Class of the University of South Florida College of Medicine stirs memories of the College's embryonal days. In September, 1971, 21 young men and three young women assembled on the fourth floor of the Science Center in the cramped temporary facilities for the College of Medicine. (Those borrowed facilities, however meager, were the focal point of our initiation into the field of medicine.) Being relatively unfamiliar with what a medical school should be, we were less concerned about the limited physical plant than our professors seemed to be.

During that first assembly, a large cadre of professors, administrators, and other important persons joined us to commemorate the start of the Charter Class and to wish us well. The one who impressed us most, the Dean—short of stature but clearly the driving force—strolled to the front of the class. After welcoming us, he assured us that the physical plant, although small, had been carefully designed to accommodate our academic requirements. To compensate for lack of tradition and space, our student-faculty ratio and relationship with the community clinicians would be uncommonly advantageous. A glance at the size of the faculty easily confirmed his comments. Probably the most reassuring note in his commentary was his emphatic presentation of an open door policy, an invitation to discuss any problems. We quickly perceived how solidly the foundation for this medical school had been laid and we acknowledged the sinewy strength of character possessed by the planners. The progress through the ensuing years reflects that strong beginning.

The First Lecture Hall

The limited facilities contributed to our class comedy. Our first lecture hall was simply a cordoned off corner of our laboratory. As the newness of the medical school wore into familiarity, the usual classroom behavior emerged. However, the group was so small that dozing through lectures, even virology lectures, was nigh impossible. Only John Elliott mastered the art of dozing,



Loren J. Bartels, M.D.

Dr. Bartels received his B.A. and M.D. degrees at the University of South Florida, where he was a member of the Charter Class. Upon completion of a residency in Otolaryngology at Geisinger Medical Center, Dr. Bartels received a prestigious fellowship in Otology and Neurotology with the Otologic Medical Group and Ear Research Institute in Los Angeles. Dr. Bartels joined the USF medical faculty as Assistant Professor, Department of Surgery in 1980. Dr. Bartels was elected to Phi Kappa Phi and Omicron Delta Kappa undergraduate academic honor societies and to Alpha Omega Alpha, National Medical Honorary Society.



always occupying a chair next to a laboratory table. Chin in hand, elbow on the table, eyelids sagging, too heavy to support — only a nudge from Luther McEachern would prevent Elliott's sonorous breathing from drowning out the lecturer.

Further back in the room, classic ripples of laughter were generated with regularity by Tom Bell, Lindsay Struthers, Gregory Piacente, and others. The back of the class, though, was so close to the front that professors such as Julian Dwornik, Ph.D., frequently caught the quip. More than once his intense face broke into laughter as he struggled to ignore the verbal antics of the back row.

During breaks between lectures, other interesting patterns of entertainment developed. Hockey was the favorite sport, crudely adapted to laboratory play with makeshift hockey sticks and pucks. Douglas Barrett and John Hellrung were the superstars, skating with reckless abandon across the glossy tiled floor, slapping the puck into the "net," an undercounter knee space, to the cheers of those less extroverted.

Rejuvenated by a schedule break, we would settle into our desks for histology. While we were concentrating on microscopic detail, though, Dr. Richard Menninger of Physiology would bring his yelping mongrels into the classroom area and set up a demonstration. Once the animals were fully anesthetized, our auditory distraction would be replaced by an olfactory one. The stench of cautery filled our nostrils, fogging not only our slides, but our minds.

Anatomy in the Afternoon

Afternoons were devoted to anatomy. Cadaver dissection for the entire class was held in a room no larger than the average operating room. Future surgeons entered this theatre with relish, operating as closely together as the stars of that notable television series "M*A*S*H." The comments were no less ribald, particularly when Martin Silbiger, M.D., shuffled in with

his stacks of X-rays to demonstrate radiographically what we were struggling to dissect. During those afternoons our clinical correlation in neuroanatomy was a high point. Dr. John Thompson, a neurosurgeon in private practice, intrigued us with illustrative case reports. He amused us with personal anecdotes and enlightened us with poetry. His dedication inspired us to make an extra effort to learn a difficult area.

The dedication of the staff meant the difference between success and failure for a few of us. Joseph Cory, Ph.D., Anthony Moore, Ph.D., and several others spent as much time as was needed to help a few members of the class overcome academic hurdles. The faculty were readily available to discuss and re-explain lecture and laboratory material. A rapport between faculty and students developed that is not possible in large groups. Often after interval and final exams, faculty and students reconvened to local restaurants to re-hash those exams over suds.

As our first year progressed, we were invited to local hospitals for acquaintance with clinical material. Medical students were as new to them, and as much of a curiosity to them, as the field of medicine was to us. Our favorite was St. Joseph's Hospital because of two factors: one was the excellent food and the other was a psychiatrist, Dr. Richard Van Sickle, whose insight into family dynamics was most entertaining, with characterizations such as the "saint and sinner" and "beauty and the beast." Psychiatry lectures opened up a dimension of medicine not studied under the microscope nor measured with sophisticated instruments.

Studying Pathology

During the broadening academic experience of the second year, we moved into a new, larger facility to study pathology. With that move came a larger coffee pot and more notable guest lecturers. Taking maximum advantage of highly esteemed guests, a few of the faculty began bringing a guest to class at very nearly the last possible moment. By then even the larger coffee pot would be down to little more than coffee grounds. On one such day our most distinguished lecturer to date arrived just in time to tip the coffee pot for its remaining dregs. As the black, muddy remains of coffee oozed into his cup, we wondered, horrified, how he might perceive his hosts. Without batting an eye, without even the slightest hint of grimace, he sipped those dregs from a cup gripped in one hand, gesturing with the other to punctuate his remarks.

With the coming of the second class of medical students, the faculty continued to grow. No longer did we know each faculty member well, nor did they all know us. In fact, one pathology professor knew us only if he had our class photographs in hand. Our unique circum-

stances became a diminishing part of an enlarging focus, a dynamic new medical school, designed to serve the changing needs of an expanding community.

When we entered our clinical years, we moved our primary learning experience into local hospitals. The Veterans Administration Hospital was newly completed with excellent lecture facilities; Tampa General Hospital, St. Joseph's Hospital, and All Children's Hospital in St. Petersburg, with their affiliated residency programs, began to build clinical experience onto our basic science foundation. Our class split up into six groups with equally varied exposures. We also began to develop relationships with local clinicians who gave us the privilege of participating in patient care. As the first crop of students, we gained opportunities seldom available to medical students. Our relatively small number afforded us an undiluted experience which gave us added advantage when we entered early postgraduate experience.

The Graduation Dinner

To close out our medical school studies in December of 1974, we all reconvened one last time with an enlarged faculty for our graduation dinner. Recalling our experiences of the prior 3½ years, we noted the

significance of the laying of the concrete foundations for the permanent home of the College of Medicine. It now seems symbolic that we, as charter class members, hence part of the living foundation of the medical school, were branching out to widely separate postgraduate programs about the same time the College of Medicine was spreading its permanent physical roots.

The ensuing 10 years have brought about the completion of the physical plant housing the medical school. With that major accomplishment, there have been equally significant changes in the numbers of faculty and students. No longer do we know the physical plant intimately, much less the people using it. The two of us who have returned as fulltime faculty see changes in the College of Medicine at the University of South Florida that are great, approximating the metamorphosis of a larva into a butterfly. But, contrary to the ephemeral existence of that butterfly, the effects of those continuing changes will benefit this area for many years to come.

Acknowledgment

Special thanks to Constance O. Bartels for her editorial assistance.



The Lady Speaks

Patricia Barry, M.D.

As its 10th anniversary year, 1981 indeed represents a milestone for the University of South Florida College of Medicine. Since this year will also present the ninth anniversary of my arrival at USF, I believe I have a relatively unique advantage; my observations have been made from three different points of view: student, house officer, and, presently, faculty member.

The Class of 1975, the second class to enter the University of South Florida College of Medicine, arrived on our Tampa campus in July, 1972. There were 24 of us—21 men and three women, ranging in age from about 21 to 31 (I had the dubious distinction of being the oldest member of the class). We were all Florida residents, but our undergraduate experience had a wide base: one-third were from USF, another third from other Florida universities, and the remaining third all from such out-of-state universities, as Notre Dame, Emory, Brown, RPI, and my own alma mater, William and Mary.

A Mixed Group

We were indeed a mixed group in terms of age, background, and marital status. Only a few of us were married, and several of the men in our class were veterans of the then-recent Viet Nam conflict. Although we were extremely heterogeneous, we soon became an extremely close-knit group; the stress of medical school enables one to find many common interests and to establish firm friendships in a relatively short period of time.

Although we were the "second class", we were unique in one way: we were to be the first class to be on a three-year curriculum. (The Charter Class had begun on a four-year curriculum, which was eventually shortened to three and one-half years). In a four-year curriculum, two nine-month terms are spent learning the basic sciences; our class would hope to cover the same amount of material in a period of approximately 11 months. Our first term, therefore, was 16 weeks and we were inundated with information, after a brief orientation period of one week. Upon reflection, the first term of medical school had been like taking a deep breath in July, diving in, being submerged for 16 weeks, and finally bobbing to the surface for another deep breath in November.



Patricia Barry, M.D.

Dr. Barry received her undergraduate education at the College of William and Mary, and New College in Sarasota and her M.D. degree from the University of South Florida College of Medicine. After completing her residency training in Internal Medicine, Dr. Barry joined the USF medical faculty as Assistant Professor in Internal Medicine. She is currently the Clinical Services Coordinator for the Suncoast Gerontology Center at USF. Dr. Barry is a member of Mortar Board, Alpha Omega Alpha and received the Dean's Award as the outstanding graduate for 1975.

Disadvantages

We were aware of some of the disadvantages of attending our new institution; the medical school had not yet been accredited, since it had to graduate its first class before it could even be eligible for accreditation. As graduates of a new school it would be our responsibility to establish the reputation of the school, rather than having the benefit of those who had gone before us to "pave the way".

No one had particularly mentioned the advantages, but, in my opinion, these were many. The small size of our class ensured a great deal of individual attention from the faculty (I suppose this could be a disadvantage if one were hoping to escape notice in some way). I expect the student-faculty ratio during that year was probably close to being one to one. We also found that our small size gave us a feeling of being a very select group (which of course we were) and really led to a feeling of comradeship, rather than competition. We tended to be mutually helpful in many ways, often studying together, and working as partners in many of our projects. It was quite common for several of us to return to the Science Center in the evening to join others for discussions and study group sessions, especially the evenings before our gross anatomy quizzes.

A One-Room Medical School

Mention of the Science Center recalls another unique experience which we had—that of attending a one-room medical school. Yes, in the true pioneer spirit, like the one-room school house so common in the West during the days of the early settlers, the USF College of Medicine in its early days provided essentially one room for its students. The elegant complex on North 30th Street was still a vision in the Dean's eyes when our class arrived on campus, and our headquarters were located on the fourth floor of the Science Center. The room was large, to be sure, (it really wasn't fair to refer to it as the Black Hole of Calcutta, although we did) and consisted of a lecture area, large laboratory bench area and student carrels placed around the periphery of the room. Our typical day would consist of an arrival at eight in the morning, followed by a series of lectures. These consisted of various professors who would emerge through a back door, lecture for an hour, and disappear through the same door, only to be replaced after a five-minute break by another faculty member.

In the afternoon, we would usually have a laboratory period of some sort in the section of the room given over to the lab benches. Tests were taken in the carrels, which could also be used for storing books and other essential items. The single fortunate exception to this environment during our first term of medical school was the gross



anatomy lab. There was a room down on the first floor of the building where the cadavers could be kept, and we would descend to that level for dissection at the appropriate time. I was always quite grateful that this additional facility was available and that we did not have to share our one-room medical school with our cadavers during other times.

The Clinical Phase

After surviving the natural science portion of our education, which we all did, we entered the clinical phase of our training. The Class of 1975 was combined with the class of 1974 for its clerkship experience, so there were 48 of us who arrived on the wards of the Tampa hospitals to begin this experience. Tampa General had had a housestaff training program for many years, so personnel there were accustomed to residents and interns. Medical students, however, were a somewhat different thing! It was a confusing experience, for not only did we not know how we were supposed to behave, but the personnel in the hospitals actually didn't either; many of them had never worked with medical students before. It was greatly to their credit, therefore, that they helped us to familiarize ourselves with the hospital and, rather than detracting from our experience, really added to it.

The VA Hospital opened approximately the same time as our class arrived at USF, and was not completely staffed when we began our clerkship. I can still remember vacant floors at the VA Hospital, with darkened rooms and empty nursing stations. However, the wards that had been opened were filled with all the necessary ingredients for medical training: patients, housestaff, faculty, nurses, and other hospital personnel.

We proceeded through our clinical years with great enjoyment, and had the pleasure, at the same time, of watching the medical school grow as the students arrived after us. The next year's class was 36 students, then 48. By the time we graduated in June of 1975, Phase I of the

medical complex had been completed, and we had the pleasure of having our reception in the dining room area of the new complex. We were also permitted by the University of South Florida to have our own separate graduation ceremony, an occasion all of us appreciated, especially considering our small size and our feeling of closeness as a group. We had been through three years together and *all* had survived. We had had moments of apprehension, of excitement, of pleasure, and finally of fulfillment—the M.D. degree.

Student Body Grows

By the time I began my internship, two weeks after graduation, the entering class had over 70 students. The full complement of 96 arrived one year later, joining us on the wards during my residency. I had elected to stay at USF for my post-graduate years, a fortunate choice. My training in Internal Medicine at USF affiliated hospitals provided an excellent experience in primary care medicine. Most of our patients were admitted to us directly from the emergency rooms or clinics, rather than being referrals. Many of them had not previously seen a physician for their presenting problem.

We found a large component of our practice was acute medicine, and there always seemed to be enough patients to provide us with a meaningful, if sometimes hectic, experience for our training. Although we were supervised closely, we were still able to assume much of the direct responsibility for patient care, a definite advantage in a clinically-oriented program.

As I proceeded through my residency years, our College continued to grow. I had the pleasure of receiving my certificate of residency in the medical school auditorium, part of the completed complex which now constitutes the physical home of the College of Medicine. When I joined the faculty, I was able to evaluate and treat patients in the Ambulatory Care Center, which is also part of that impressive facility. In my first year on the faculty, I had the unique experience of being chairperson of the subcommittee involved with designing a new four-year curriculum for the College of Medicine. Many of the people on this committee had been faculty members when I was a student, and most of us had experienced the three-year curriculum from the vantage point of either student or teacher.

Four-Year Curriculum

In 1980, the College of Medicine admitted the first class which will be on this four-year curriculum. When there are four classes here, the full complement of students will be almost 400 - a far cry from the 48 that were here when I first arrived.

The faculty, too, has grown in size and prestige. All of us in the early days were impressed with the foresight

and creativity of our early “founding fathers”, led by Dean Donn Smith. We have indeed been fortunate in the leadership and imagination evident in our departmental chairmen from those early days. Our clinical departments now cover all major specialty and subspecialty areas, and preclinical areas have expanded with equal force quite impressive, considering the handful of faculty covering each department back in 1972.

What Has Been Accomplished

What has the University of South Florida College of Medicine accomplished in 10 years? From my own perspective, a great deal indeed. We were charged by the State of Florida with the creation of a medical school which would turn out practicing physicians who would serve the citizens of our state. Our approach, therefore, was first to develop ourselves as an educational institution for the purpose of producing students and housestaff who were well trained in clinical science. In this, I feel we have succeeded extremely well.

I have had the pleasure of supervising our own trainees on the wards, not only as students, but also as house officers in our training programs. They have consistently been of the highest quality. Their ability to care for patients has been unsurpassed by any housestaff that we have acquired from other medical schools.

We have also established ourselves as a center for health care, both outpatient and inpatient, for our surrounding area, with its large population and rapid growth. Having succeeded admirably in attaining our primary objective, we have begun to address the other areas that need to be developed. Our research programs are proceeding in an exemplary fashion, and we are rapidly establishing a reputation as a major referral center for the surrounding counties of central Florida. We have the great fortune of being located in a center of rapid growth, with a solid business-industrial economic base, lending considerable stability to the area.

A Unique Opportunity

Reflecting on my own experience, I realize that USF has provided me with a unique opportunity that would not have been available at any other medical school. Following college graduation, I had worked as a research chemist, wife, and mother, before USF granted me the opportunity of attending medical school. Had I entered medical school directly after graduating from college, I would not have been able to attend USF, since it had not opened at that time. I have realized in recent years that the disadvantage of my “late start” has been overcome by the great advantage I have had in being a part of the progress of this College of Medicine from its early years, through its rapid growth, to this, its 10th anniversary.

A Student's Perspective

Kenneth L. Schiffman

Most veterans of undergraduate medical education likely would agree that being a medical student is for the most part a common experience. However, in speaking with medical students from other institutions in various parts of the country, I have learned that there are many subtle differences which give each school its own personality.

The University of South Florida College of Medicine has developed a personality which reflects, in addition to many other factors, its youth and its location. Tampa, a progressive community, has encouraged advancement in the development of our College of Medicine. This brief scenario should, from a student's perspective, give the reader a feeling for where our College is and where it will be in the future.

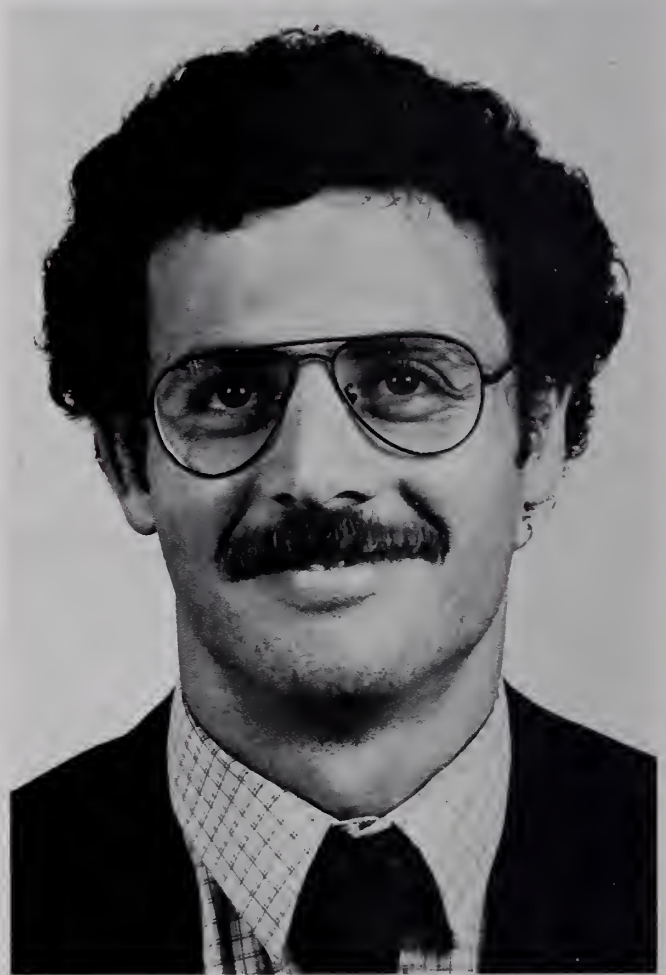
Applying to Medical School

It seems logical to begin this discussion with the process of applying to medical school. Being accepted is a challenge wherever one applies and the interview is obviously an integral part of the process. The Admissions Committee, in evaluating the applicant, would like to know as much as possible about that person's academic ability and personality.

The method of interviewing varies somewhat between institutions. At USF, this interviewing experience is a relatively unique one. The interview is conducted by a committee which includes representative faculty and students who, after reviewing the application and records, gather and as a group, meet with the applicant. For those applying, this can be a highly stressful situation. After all, this is a one-time opportunity to convince a group of very scrutinizing individuals that you are "the one" out of every nine that should be admitted to USF.

The Interview

In retrospect (and at the risk of being somewhat biased), my interview at USF was certainly the most effective; that is to say, the most effective in evaluating one's character and sincerity in pursuing a career in medicine. An individual's level of success in medicine is



Kenneth L. Schiffman

Mr. Schiffman is a senior medical student and President of the Student Body at the University of South Florida College of Medicine. He is a graduate of the University of Miami where he was a member of the Interfraternity Council, a member of the M circle K club and the winner of the Barbash Honors Scholarship.

He has been elected to Alpha Omega Alpha at USF College of Medicine where he has excelled in academics and leadership.



not only related to the ability to establish a differential diagnosis but also to the capacity for making mature, responsible, under pressure decisions. I believe that the Admissions Committee has this idea primarily in mind when evaluating applicants and it seems to be reflected in a positive way in the caliber of those graduating from this College.

At this institution, the medical school career starts with an orientation week when the new students are exposed to basic science and clinical faculty. The purpose of this week is to welcome the students, familiarize them with the typical routine and surroundings, while at the same time, easing them into the start of classes. There is a traditional freshman picnic which is sponsored by the Dean and planned by the Sophomore Class and is held on the week-end following orientation. This is a day of good times and good food for students, friends and faculty and really helps make new students feel like they are a part of the College.

The attitude of the new class can be described in two words: enthusiasm and apprehension. Fortunately, after

the first set of exams, the feelings of apprehension fade and the contrast between undergraduate school and medical school becomes obvious. What has been most surprising to me as a medical student is the attitude of the faculty. I feel as though they were primarily concerned about my education rather than my test scores and were glad to stop and clarify any problem, even after hours or during lunch. It is an adjustment to realize that your professors are now also your friends and colleagues.

Extracurricular Activities

Extracurricular activities have traditionally been of great importance to the medical students at this College and deserve some discussion. Some of these activities are intramural athletics, community projects, student government, monthly College of Medicine parties and participation in specialty clubs and organized medical associations.

Many of the students, both female and male, take part in intramural sports and have brought quite a reputation to our College. We are active in football, softball, basketball and soccer and have won quite a few university trophies over the years. Participating in sports helps release some of the tension associated with medical school by bringing the students together in a setting other than the classroom or the hospital ward. These activities also bring us in contact with university students who we otherwise would see infrequently.

Many of the students are active in organizations such as the American Medical Association, Florida Medical Association, Hillsborough County Medical Association, Association of American Medical Colleges, and the Florida Academy of Family Physicians. These affiliations enable students to share ideas and experiences with those from other colleges of medicine. Students also come in contact with practicing physicians who are more than willing to discuss issues which will directly affect them in the near future.

Student Government

The student government at the College of Medicine works closely with the undergraduate student government and the students of the College of Nursing in organizing lectures and events dealing with topics such as sports medicine, trends in providing group health care and caring for the terminally ill patient. Those students who are active in our College Student Council have met with politicians and business people from the Tampa area in an effort to let them know that we at the College are a part of the community.

Many students have had the pleasure of working with members of the clinical faculty at outlying voluntary health care clinics for the underprivileged. This serves to bring health care to those in the community who would

otherwise not be able to obtain it and also gives those of us in training additional experience in primary care medicine.

During the senior year which is a year of elective rotations, many students visit other institutions for externships. These are simply elective rotations in various specialties at programs throughout the country for periods of up to two months. This is a significant opportunity for students considering taking their postgraduate training at specific programs to determine, on a firsthand basis, which program may be best for them and vice versa. This also grants one the opportunity to contrast how training is carried out elsewhere.

Four-Year Curriculum

Our College is young and progressively changing. The newest change is from a three to a four-year curriculum which was initiated with this year's freshman class. Some might argue that this is hardly an advance-

ment as the four-year curriculum has been the standard for the great majority of U.S. medical schools. However, for the students here this is indeed a progressive change for although the total number of hours of instruction will be equivalent, the flexibility in an individual's training will be expanded. Often times, a three-year curriculum does not allow the time for exposure to the world outside the academic medical environment. The four-year curriculum will allow for diversification in both medical and non-medical experiences.

The student body has also grown in number as has the population of Tampa and the need for a university hospital continues to be felt. A facility such as this represents a considerable cost to the public and therefore must be justified by a need within the community. With the present growth of the Tampa area and the State of Florida, we, as students of the University of South Florida College of Medicine and as members of the community, hope to see our institution continue to maintain excellence in health care services.



Charter Class and Faculty
First Day of School

Admissions

The College of Medicine at the University of South Florida was authorized by the Florida State Legislature in 1965. In October, 1969, the Florida Board of Regents approved the appointment of Donn L. Smith, M.D., Ph.D., as the first full-time Dean of the College and Director of the Medical Center. From that time to September 8, 1971, the Dean and the Charter Faculty were able to overcome a number of obstacles and were authorized to admit the first class of 24 entering medical students.

The Charter Class, all Florida residents, was comprised of 21 male and 3 female students who were selected from 389 applications by Florida residents and 11 from non-Florida residents. The Charter Class graduated in December, 1974. Since 1976, the College has been accepting 96 entering students per class.

Inasmuch as the College is a State supported institution, the College of Medicine has placed much emphasis on the selection of well-qualified Florida residents. From 1970 to 1979, there were 7,902 formal applications filed by Florida and non-Florida residents. Of this number, 7,669 (97.1%) were from Florida residents and 233 (2.9%) were from non-residents. Acceptances were offered to 693 Florida residents and 6 non-residents for a total of 699 students who matriculated in the College from September, 1971 to July, 1980.

Basis for Selection

Students are not selected solely on the basis of their grade point averages and performance on the New Medical College Admission Test. Other factors are also carefully evaluated such as emotional maturity, character, motivation, stability, and extracurricular involvement. The College seeks students with diverse interests who are well-rounded in all aspects; this constitutes well-qualified.

The 693 Florida residents, who have matriculated in the College from September, 1971 through September, 1980, have been selected from 45 (67.2%) of 67 counties in the State (Figure I). Also, students have been selected from 4 additional counties in the State (Figure I), but they

elected to matriculate at other institutions. Therefore, we have in effect accepted students from 49 (73.1%) of 67 counties. Although the College has not matriculated students from 22 of Florida's 67 counties, well qualified applicants applying from counties in which there are relatively few people residing, are viewed with special care inasmuch as the College is committed to serve the needs of the entire State. All efforts are being made to have student representation in our College from all 67 counties as soon as possible.

Furthermore, in keeping with our commitment to serve the residents of Florida, 248 (35.5%) of the 699 matriculating students were born in the State. Likewise, 593 (84.8%) of the 699 students took either part or all of their high school training in the State of Florida.

Minority Students

Well qualified students of varying ethnic backgrounds have also been given special consideration. Fifty-four (7.7%) of 699 students matriculating from September, 1971 through September, 1980 were from minority backgrounds.

There is often concern in new schools that the small initial classes combined with relatively limited numbers of applicants might result in more homogeneous student bodies than would be expected in later years. Such has not been the case at the University of South Florida College of Medicine which has been fortunate in maintaining a heterogeneous student body from the beginning. The diversity of backgrounds and interests are emphasized by the fact that our 699 matriculating students came to us from 91 different undergraduate institutions.

The 1971 charter class of 24 came to us from nine schools whereas the 1980 entering class of 96 received their training at 32 different colleges and universities. The number of institutions represented in the classes between these years increased steadily as the class size grew to its present maximum of 96 in 1976.

Our first decade saw students coming from a total of 91 institutions. Four hundred and twenty two (60.4%)

individuals had attended one of the 9 universities in the State University System. In addition, 86 (12.3%) took their premedical training at 12 other Florida colleges and universities. The balance came from such widely varied areas as, to mention but a few, Emory, West Point, John Hopkins, Notre Dame, Vanderbilt, Mount Holyoke, Cornell, Tulane, University of Michigan, Dartmouth, Indiana and Duke. Applications have been received from every geographic area in the United States. Matriculated students have come from all but the west coast.

The College graduated its Charter Class in De-

cember, 1974. Through June, 1980, we have graduated a total of 396 physicians, 327 (82.6%) were males and 69 (17.4%) were females. In keeping with our commitment to serve the citizenry of the State in an objective, equitable manner, we have tried to eliminate biases and external forces that could adversely influence the decisions of the Committee on Admissions.

The following table summarizes a few major quantifiable factors that have been considered in the overall selection process for students matriculating from September, 1971 through September, 1980.

Student Matriculation in the College
From September 1971 through September 1980

Total Matriculating	Florida Residents	Non Residents	Males	Females	Minorities	Number From SUS*	Number Born Florida	Number With All Or Part HS** In Florida
699	693	6	566	133	54	422	248	593
Percent	99.1	0.9	81.0	19.0	7.7	60.4	35.5	84.8

*State University System

**High School



The Student Body

A keystone in the faculty-student relationship at the College of Medicine was stated in the initial mimeographed sheet regarding admission, "In accepting a student for admission to the College of Medicine, the faculty has demonstrated that they regard the student as a junior professional colleague. The student of medicine therefore is expected to demonstrate a professional appearance and demeanor commensurate with his position. Conduct short of this standard, especially in a professional surrounding, will be adjudged to be unsatisfactory."

From the initial 24 students to the nearly 300 present students this behavior code has been honored. The fact that three members of this year's Senior Class attended the last day of Gross Anatomy two years ago wearing neatly tied ties, shirts and coats all on backwards should be regarded as a minor deviation from this standard, rather than as the usual form of attire.

Code of Honor

In addition to this statement of conduct, the Charter Class composed the following Code of Honor which has been signed by each entering student ever since. "I hereby agree to dress, groom and conduct myself in a manner appropriate and expected of the practicing community physician. I also agree to sign my name at the end of each quiz and examination. This signature indicates that I have not used or been given any form of assistance in writing my quizzes and examinations. It is understood that I am guilty of breaking this Code if I do not report to the examiner someone who has willfully committed this type of offense."

Just as the students participated in writing their own honor code, they have been active in other affairs of the College. Each major search committee, the Student Affairs, Admissions, and Curriculum Committees have always had student members who have played important roles in their functioning. This active membership has been of great value because the faculty is well informed as to "how the students felt" about any given issue.

One area in which there has been no unanimity among the students concerns the grading system. The

College opened with an "Honors, Pass, Fail" grade scale and it is basically still in effect today. Each year a small segment of the student body desires to switch to a numerical or letter grade system, but this group has never been able to gain the support of the majority of the student body. Faculty feelings have followed a similar pattern, it should be noted.

Class Officers

Each class elects its own officers every year. In addition to these class officers the student body has its own officers who represent the College and who participate in the student government activities of the University of South Florida.

Two questions left open to the first students were their interest in medical fraternities and a Student American Medical Association chapter. Thus far there has not been a demonstrated interest to organize chapters in any of these groups.

Activity in intramural athletics, however, did not need any encouragement. A full slate of teams has been fielded every year since our opening. The College of Medicine Charter Class basketball team may have been a leader in the nation in a male-female mixed lineup during part of its season that first year. In 1974, our teams won trophies for overall championship performance in USF intramurals. In all honesty, the fact that one of the students had been a former All-Southeast USA High School basketball player and at times carried the load for some of his teammates in the Charter Class must be mentioned. Since 1974, the students have trophies for being Intramural Independent League Champions in 1977-78, 1978-79, and 1979-80. They have also been 1978 and 1980 softball champions.

Cost of Medical Education

The cost of a medical education continues to be a tremendous burden for our students and their families. Over two-thirds of our student body qualify for financial aid based on their parental income and assets. The current average total cost of a year of medical education at USF is approximately \$8,500; this includes tuition,

books, equipment and cost of living expenses.

Another problem facing new schools—and ours has been no exception—is the fact that there are no alumni funds to help provide some degree of financial aid for its students. Only now are some very welcome alumni donations starting to come in for this purpose. Coupled with this lack is the absence of repayments of student loan funds which can be recycled to needy students. This source of loan money is also just starting to come in from graduates who are now finally seeing something other than red ink.

A formal and informal counseling system has been used to help students who have financial, academic or personal problems. Generally, it has worked well. The upper classmen have also been extremely helpful in counselling incoming students. The “we’ve been through it” knowledge and advice from these people have been a great asset to many a first-year student. Having a three-year curriculum for most of the past 10 years has made it more difficult to arrange for course repetition for students, but the faculty and administration has been as flexible as possible in making arrangements for students with partial academic deficiencies.

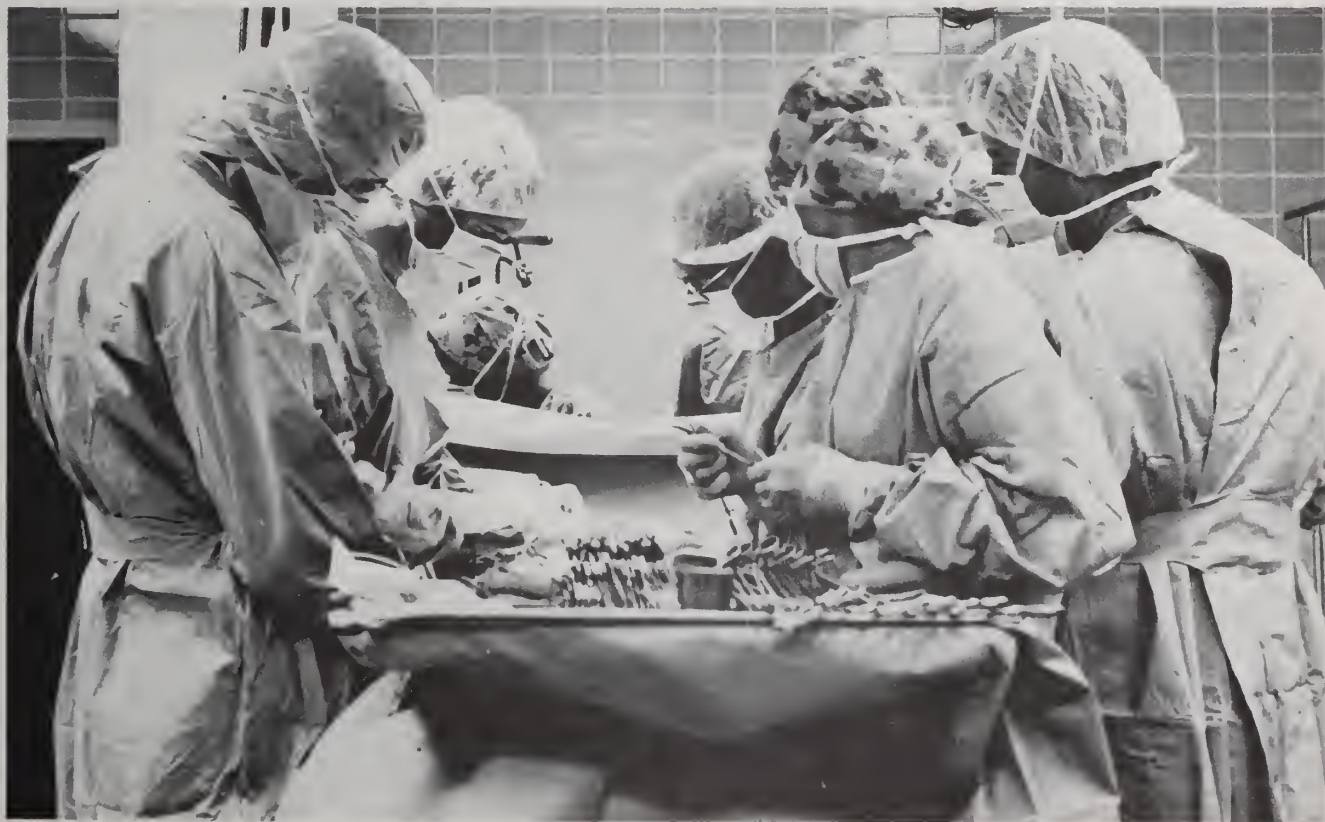
Our students have consistently done well in the National Resident Matching Program. Over 60% of our graduates have received their first choice and 90% match with one of their first three choices.

Preference for Primary Care

USF graduates have shown a preference for the primary care specialties of Internal Medicine, Family Medicine and Pediatrics. Fifty-three percent have entered residencies in these areas and an additional 10% have entered Ob/Gyn. Surgery and the surgical subspecialties have attracted 15% of our graduates. Over 90% select training programs with a university affiliation.

Since the majority of our graduates are still in residency or fellowship training, it is too early to accurately predict the percentage who will return to practice medicine in Florida. Early indications are that approximately 45% will do so. We currently have four of our graduates who hold full time positions on our faculty.

The State of Florida can take pride in the graduates from our College of Medicine. They have been trained well. They have performed well in training programs from coast to coast in the United States. From all indications they have completed their medical school training and retained their humanistic feelings for their patients. They have worked hard, but still generally seem to be smiling as senior medical students, and have not been dehumanized by “the system”. They have been and will continue to be a joy to the faculty who watch their development and a great asset to the citizens as fine practitioners.



Curriculum at the University of South Florida College of Medicine

The objectives of the educational program of the University of South Florida College of Medicine were listed in our first bulletin as follows:

- "(1) to provide conceptually oriented teaching which will afford the student a challenging intellectual experience rather than the routine and superficial large volume of fact presentation;
- "(2) to encourage close student-faculty relationships so that the students will regard the faculty not as teachers of didactic information, but rather as guides to learning;
- "(3) to achieve a visible and effective correlation between the preclinical and clinical instruction;
- "(4) to increase the correlation on an interdisciplinary basis so that adequate reinforcement may occur between the various fields of study, especially the preclinical and clinical courses;
- "(5) to provide a close and ongoing experience for the student in the day-to-day and continuing health care delivery system within community hospitals and in ambulatory care facilities, thus to produce graduating physicians who understand and desire the practice of medicine as a fruitful and meaningful choice for a lifetime career of service to their patients and community."

These objectives have been carried forward through several curricular changes and they continue to constitute present goals just as fully as they did in the past.

Traditional Curriculum

The College of Medicine, University of South Florida, opened on September 8, 1971, with a four-year curriculum developed along traditional lines. Despite consideration of innovative techniques presumed to be possible only in a new school, it was decided because of a small class and a relatively small and newly assembled faculty, to adhere to the customary two years' basic

science followed by a year of clerkships and another of electives. Certain variations from tradition were adopted however, chiefly an earlier exposure to clinical experience and greater coordination between the various disciplines.

The first two weeks were devoted entirely to clinical orientation in our teaching hospitals. Presentation of patient problems illustrating the relationship between basic sciences and the practice of medicine were supplemented by guided tours of standard hospital departments such as Pathology, Radiology, Admissions, Records, Nursing Service, etc. These proved to be desirable additions to the curriculum. Correlative exercises were continued throughout the first year and some of the basic science departments also made considerable use of clinical faculty from time to time to supplement basic presentations.

All of the anatomic disciplines (Gross Anatomy, Histology, Neuroanatomy, Embryology) were next completed during the first 11 weeks of the year with the students working exclusively in these areas. (Members of the Anatomy Department later expressed the opinion that this total exposure to their disciplines was less than ideal: the students presumably would benefit from a "change of pace.") The remainder of the first year covered the basic sciences of Biochemistry, Physiology, Microbiology, Pharmacology, with a projected additional exposure to Human Biology, Biostatistics, and an Introduction to Psychiatry.

The second year was devoted to Pathology, including Laboratory Medicine, and Introduction to Medicine plus Physical Diagnosis, with Tutorial Clerkships planned as an introduction to the regular clerkships projected for the third year. A basic science review was scheduled for the end of the second year to provide better preparation in the fundamental backgrounds of clinical medicine. The third year was to be devoted entirely to clerkships and the fourth, totally elective. (Table I) The first class, enrolled in 1971, followed this pattern for two years though the schedule was thereafter considerably changed as will be noted.

USF COLLEGE OF MEDICINE
INITIAL CURRICULUM - 1971
(CHARTER CLASS)

TABLE I

	Sep 1971				Jun
MED I	Clin. Orient. 50 hrs Embryology 2 hrs	Anatomy (incl. Gross, Histol, Neuro) 324 hrs	Biochemistry 173 hrs Physiology 173 hrs Human Biology and Correlation 24 hrs	Med. Micro. 173 hrs Pharmacology 173 hrs Human Biology and Correlation 22 hrs	Intro. Psychiatry and Biostatistics 72 hrs

36 weeks

	Sep 1972				Jun
MED II	Intro. Med (incl. Phys. Diag.) 432 hrs Pathology (incl. Lab. Med.) 432 hrs	Intro. Med. (incl. Phys. Diag.) 432 hrs Pathology (incl. Lab. Med.) 432 hrs	Basic Review 200 hrs Tutorial Clerkships 160 hrs		

36 weeks

	Jul 1973				Jun
MED III	Clinical Clerkships 1440 hrs				
	Clin Clk 480 hrs		Clinical Clerkships 960 hrs		
	Clinical Clerkships 1440 hrs		Clin Clk 480 hrs		
	Clinical Clerkships 1440 hrs				

48 weeks

	Jul 1974				Jun
MED IV	Electives 1440 hrs				
	Electives 480 hrs		Electives 960 hrs		
	Electives 960 hrs		Electives 480 hrs		
	Electives 1440 hrs				

48 weeks

Subject Oriented Curriculum

The curriculum received intensive study by the Curriculum Committee during the first year. Serious consideration was given to the introduction of a disease oriented approach as an alternative to the standard subject oriented pattern. Though there was considerable support for this concept, it was finally decided that such a system would not be adopted.

For some years there had been a widespread impression that traditional patterns made undue demands upon the length of time spent in training. It was often pointed out with considerable justice that four years of college, four in medical school, and two to four in hospital training plus a then nearly universal requirement of two years of military medical service consumed a total of 12 to 15 years in preparation for practice—widely considered to be an unduly great proportion of the lives of those entering the practice of medicine. Further, tuition and the cost of living were rapidly increasing. In response, shortening of the total medical curriculum and a decrease in required pre-medical years were accomplished in an ever increasing number of medical schools.

Three-Year Program

With these considerations in mind, the possibility of reducing our basic pattern of four nine-month years to three years of 11 months each was given serious consideration by the faculty as the first year progressed. Favoring a shorter program was widespread concern over the adequacy and distribution of medical care and the possibility of gaining an additional year of productive activity for each student by shortening the total curricular time. Increasing acceptance of postgraduate hospital experience provided an additional argument for shortening the basic curriculum to permit earlier hospital apprenticeships following graduation.

Potential disadvantages related to the resultant rapid student progress through a wealth of material, with perhaps too little time for deliberate thought and assimilation. For the faculties, a serious problem would be the need for additional staff in order that necessary vacations and time for research not be sacrificed to constant instructional obligations. Further, the three-year curriculum would inevitably demand far greater coordination between departments; time demands upon the faculty would be multiplied far more than is apparent on casual inspection of proposed class schedules. Nevertheless, the ultimate decision was to institute a three-year 33-month program beginning with the second class, in July of 1972.

A further problem was presented by the possibility of simultaneous graduation of our first two classes. From several options offered them, the Charter Class elected to devote 12 months of their junior year to clerkships and

to give up one-half of the fourth year's elective time. Careful analysis of this plan indicated that it would produce no loss of essential educational experience, hence there was no valid objection to this pattern which would enable graduation of that first class at mid-year.

A new three-year curriculum was divided into three quarters for the first academic year: the first devoted to Anatomy, Biochemistry and Physiology; the second to Medical Microbiology, Pathology, and Introduction to Medicine (including Tutorial Clerkships and Physical Diagnosis); the final quarter of the initial year included Pharmacology, Introduction to Psychiatry, Clinical Laboratory Medicine, and Introduction to Medicine, the latter an inter-departmental effort providing a preliminary overview of various fields of medicine.

Clerkships

The second year was devoted to clerkships, 12 weeks each in Medicine and Surgery, with 8 week segments for Obstetrics/Gynecology, Pediatrics, and Psychiatry. The final year was totally elective with courses varying in length from 6 to 12 weeks each. Not more than one-half of the total elective time could be devoted to any one discipline, but otherwise wide freedom of choice was allowed. Off-campus electives were available at other schools or in properly approved and accredited hospitals in other centers.

As we completed the second year of this curriculum certain basic problems became apparent. Initial faculty concern about pressures was confirmed by both faculty and students. Too little time had been allowed for Anatomy and Physiology. The clerkships in Medicine and Surgery, while adequate for basic experience, allowed too little time for exposure to the sub-specialties. Additional vacation time appeared to be desirable particularly in the form of breaks between curricular segments.

To meet these difficulties the Curriculum Committee, though following the same basic pattern, extended each of the first two years by three months. A week was provided for examinations at the middle and the end of each term with departments asked to limit testing to these periods, thus minimizing episodic competition for students' time and interest. A total of 7 weeks of vacation time was added. Assignments to Medicine and Surgery were 12 weeks each, with Pediatrics, Psychiatry, and Obstetrics/Gynecology each receiving 8 weeks. To achieve these adjustments, the elective program was shortened to 36 weeks, it being generally agreed that it is difficult to justify an entire year of electives in a three-year curriculum; the new plan offered electives of 12, 6, or 4 weeks duration. (Table II)

The basic curricular patterns described were in effect throughout the academic experience of the first

USF COLLEGE OF MEDICINE THREE-YEAR CURRICULUM TABLE II

	Jul	Jan	Jun	Sep
MED I	Clinical Orientation Anatomy (Gross, Histol, Neuro) 340 hrs Physiology 200 hrs Biochemistry 180 hrs	Med Micro 187 hrs Intro Med (incl. Phys Diag. and Tutorial Clerkships) 170 hrs Pathology 255 hrs	Intro. Med. (incl. Phys. Diag. and Tutorial Clerkships) 240 hrs Lab Med 60 hrs Intro. to Psychiatry 60 hrs Pharmacology 180 hrs	

58 weeks: Basic Sciences

	Oct				Sep
MED II	1/2 Class Medicine 12 weeks		Surgery 12 weeks	Pediatrics 8 weeks	Psychiatry 8 weeks OB/Gyn 8 weeks
	1/2 Class Pediatrics 8 weeks	Psychiatry 8 weeks	OB/Gyn 8 weeks	Medicine 12 weeks	Surgery 12 weeks

48 weeks: Clerkships

	Oct	Jun
MED III	Elective Courses (12, 6 and 4 weeks)	

36 weeks: Electives

seven classes to graduate from this College of Medicine. There has been steadily increasing agreement that additional time, including vacations, together with some redistribution of curricular hours would be not only justifiable but in fact most desirable.

Return to Four-Year Curriculum

Early in the academic year 1979-80, the faculty unanimously voted to return to a four-year curriculum and the Curriculum Committee was charged with the development of mechanisms by which this could be accomplished; particular consideration was to be given to problems which might be posed thereby for students already enrolled.

Subcommittees considering the first two years of the proposed four-year curriculum devoted considerable time not only to a study of time distribution among the various subjects, but also to an analysis of the effectiveness of such distribution as judged by the faculties teaching in those areas.

Based upon these deliberations the following changes were adopted: Preliminary orientation relative to the first basic science segment and the instruction in first aid and cardiopulmonary resuscitation would be accomplished during the latter part of the registration week which normally follows the Labor Day holiday. This offered a distinct advantage in that all courses could start their serious work without interruption at the beginning of the first full week of classes. Significant increases in time devoted to the various phases of anatomy were instituted to permit better assimilation of these disciplines without increase in covered subject matter.

Other redistributions were accomplished as illustrated in Table III. This new program is based upon a 37½ week first year with a more traditional 2½ month interval between the first and second years. The program for the second year is self-explanatory as illustrated. The third academic year will continue to be devoted to clinical clerkships following the basic pattern already in effect. The final year will be elective and at least at the outset will follow the same plan most recently used.

Curricular patterns have thus come full circle from

the traditional program initially projected, through extended experience with a three-year pattern, with final return to the more traditional four academic years separated by generous vacation periods. Obligations to students enrolled under the previous program have been fulfilled by permitting them to graduate exactly as they had expected when they first enrolled. They have, however, been given the option of electing a fourth year either between the basic science segment and the clerkships or at the conclusion of the clerkship programs. These options, together with the assurance that the previous commitment permitting them to graduate at the end of three years, could be adhered to, met with complete approval of students already enrolled. It is interesting to note that the majority elected a total three years' enrollment rather than to graduate only after four years.

Future Changes

The future may well bring further changes and the breathtaking rapidity of medical progress will undoubtedly require further readjustment of the curriculum in years to come. Whatever the changes, however, they will surely be of benefit to the student so long as the faculty continues to fulfill its ultimate responsibility for success or failure in terms of the ultimate product—the practicing physician. Great teachers have stood out through the years, not because of their courses or their schedules, but rather through their ability to stimulate and inspire students regardless of the situation in which they together were working. These conclusions were beautifully summarized by one of today's outstanding medical educators, Dr. J. Engelbert Dunphy of the University of California, in an address entitled, "Not From a Curriculum":

"Identification between student and professor at the laboratory bench is the true joy of science. Identification of the student with the professor at the bedside, in the clinic and in the operating room is the true joy of medicine. Any curricular change which accomplishes this will be eminently successful. To the extent that it does not, it will prove disappointing."

USF COLLEGE OF MEDICINE FOUR-YEAR CURRICULUM 1980 - TABLE III

	Sep 1980	Jan	Jun
MED I	Orientation First Aid		
	Biochem 90 hrs	Biochemistry 70 hrs	Physiology 204 hrs
	Histol 100 hrs	Neuro Anat 100 hrs	Med Microbiology 204 hrs
	Embryol 10 hrs	Gross Anat 115 hrs	Phys Diagnosis 85 hrs
	Gr Anat 100 hrs	Embryol 5 hrs Publ. Hlt. 10 hrs	Public Health 51 hrs
37 weeks			

	Sep 1981	Jan 1982	Jun
MED II	Gen Path 72 hrs	Systemic Pathology 150 hrs	Pharmacology 180 hrs
	Beh Sci 48 hrs	Intro to Clin Med 210 hrs	Lab Medicine 21 hrs
	Lab Med 24 hrs	Physical Diagnosis 45 hrs	Intro to Clin Med 165 hrs
	Phys Diag 18 hrs	Lab Medicine 30 hrs	Physical Diagnosis 60 hrs
	Int. Clin Med 18 hrs		Cross-Sect Anatomy 24 hrs

	Jul 1982	Jan 1983	Jun
MED III	1/2 Class Medicine 12 weeks	Surgery 12 weeks	Pediatrics 8 weeks Psychiatry 8 weeks OB/Gyn 8 weeks
	1/2 Class Pediatrics 8 weeks Psychiatry 8 weeks OB/Gyn 8 weeks	Medicine 12 weeks	Surgery 12 weeks
48 weeks: Clerkships			

	Jul 1983	Jan 1984	Jun
MED IV	Electives - variable length		Electives - variable length
48 weeks: Electives			

Hospital Affiliations

1. Tampa General Hospital

Tampa General Hospital has served the Greater Tampa Bay area for more than 50 years. A fullservice institution representing a combination of public and private care programs, Tampa General has a long tradition of serving as "the hospital" for trauma and other emergencies. At the time the University of South Florida College of Medicine opened, some residency programs were already in operation (see article titled "Residency Training Programs," elsewhere in this issue).

Although a teaching hospital with detailed projections was included in the initial grant application as a part of the original planning for the College of Medicine, it was obvious that with the College opening in 1971, major teaching affiliations with community hospitals would be necessary to provide initial clinical facilities and the basis for programs in the future. Tampa General Hospital appeared to be the obvious first choice to serve in addition to the Veterans Administration Hospital already under construction adjacent to the medical school site. It was clear that even with the presence of a University Hospital on the campus, affiliations with community hospitals would be a permanent feature in the conduct of medical education by this University.

Teaching vs. Private Practice

A major problem in the initial negotiation between the College and the Hospital related to the separation of medical education from areas of private practice because a number of medical staff preferred not to engage in teaching activities. It was agreed that Medical School faculty members would be members of the hospital staff and subject to its bylaws, and that private practitioners would be admitted to faculty status only upon approval by the College of Medicine.

The College further agreed to undertake the medical care of all indigent patients admitted to the hospital and its outpatient clinics. The medical faculty, as members of the hospital staff, could admit their private patients to the hospital on the same basis as any other members of the staff. The house staff would provide service to non-teaching physicians on the hospital staff in emergency

circumstances and in life threatening situations.

This affiliation, tailored to fit the local scene and negotiated over a period of months, still stands and functions well. As part of its obligation, the College pays approximately 37 percent of the resident staff's annual salaries. This amount represents that portion of housestaff time relegated to educational activities. It is significant that there has been substantial increase in the number and quality of the residency training programs since affiliation with the College of Medicine. These changes are well described in the section on residency programs.

New Governing Board

By state legislative action in the spring of 1980, the old Hospital and Welfare Board of Hillsborough County was dissolved and the new Hillsborough County Hospital Authority became the governing board of Tampa General Hospital. Nominations and appointments for seats to the nine-member Authority are approved by the Hillsborough County Board of Commissioners.

This 600-bed hospital admits more than 25,000 patients every year and the emergency room treats approximately 45,000 patients per year. The hospital has undergone marked expansion and extension of its programs since the advent of the College of Medicine and it now includes specialty programs such as cardiac intensive care, neonatal intensive care, a burn unit, renal transplantation program, a gastrointestinal center and renal dialysis.

Several of these developments are a direct result of the presence of the College of Medicine and thus are of considerable benefit to the community. Predictably, some difficulties have arisen on occasion in the interrelationship between the College of Medicine and Tampa General Hospital, but the hospital continues to serve effectively for instructional programs in the clinical areas both at the undergraduate and graduate levels. Tampa General Hospital and the Veterans Administration Hospital continue to be the major teaching hospitals for the College of Medicine, and represent an essential asset value for the College.

2. Veterans Administration Hospital

The Tampa Veterans Administration Hospital, situated directly across from the University of South Florida College of Medicine, was built specifically to support the medical school. It was established as a "Dean's Committee Hospital" following the pattern of university affiliation for teaching at all levels developed by the Veterans Administration through the efforts of Paul Magnuson during World War II.

That designation meant that the medical schools concerned were expected to maintain a major interest in the operation of the hospitals and to exert a major voice in their policies. This included mandatory Dean's Committee approval of all professional appointments. It thus became the first hospital in the area with residency programs completely controlled and directed by the faculty of the College of Medicine. As might be anticipated, unfamiliarity of some hospital administrative personnel with operation of this type of institution brought some conflicts in the early days of function, but the hospital soon became and continues to be a major element in the clinical programs of this College of Medicine at both undergraduate and residency levels.

The James A. Haley Veterans Administration Hospital as it is known, is a 697-bed general medical and surgical facility providing health care services to veterans of Central Florida. More than 18,000 patients are admitted annually and the medical staff is composed of more than 200 full and part-time physicians and residents. All chiefs-of-service hold key departmental posts in the College of Medicine. Though certain teaching facilities were neglected in the initial planning, the hospital has nevertheless made available much needed space for conferences and small group academic activities. These have been of the utmost value, particularly in view of the fact that such facilities are of limited number elsewhere.

Specialized Procedures

This Veterans Administration Hospital is staffed and equipped to perform highly specialized procedures. These include cardiac catheterization, open-heart surgery, hemodialysis, kidney transplantation, electron microscopy, and a special unit for training patients in home dialysis. A separate small medical research building provided in the initial plan has made possible many diversified fields of research study. This unit was particularly helpful for faculty research projects on a cooperative basis while the medical school facilities were under construction.

Despite the small number of patients in the field of gynecology and the absence of pediatric programs, this institution nevertheless constitutes a major asset among

the clinical facilities available to this College of Medicine. Not the least of its advantages is that conferred by the Dean's Committee function which insures a faculty voice in all operative decisions which might affect academic programs.

3. St. Joseph's Hospital

St. Joseph's Hospital is a 577-bed institution operated by the Franciscan Sisters. It is a completely private full-service facility with excellent programs in all of the major specialties. An affiliation agreement with the College of Medicine was developed initially and this agreement remains in operation today. A highly cooperative attitude, the excellent teaching auditorium and the facilities of the mental health center were of great value especially in the early development of clinical teaching programs.

One of the many unusual services provided by this hospital is the cost-controlled Surgicare Unit—a one-day program providing professional services for patients in need of minor surgery and diagnostic or therapeutic procedures not requiring longer hospitalization. This hospital has developed other cost-reducing resources including outpatient programs for physical therapy, radiation therapy, and respiratory therapy.

The Fred J. Woods Radiation Therapy Center offers a full range of sophisticated radiation therapy equipment with a highly trained professional staff. Much of the radiation therapy for the Veterans Administration Hospital is provided by this Center under contract with the Veterans Administration.

Eye Surgery

The majority of eye surgery in Hillsborough County is done in this institution. A daily average of seven surgical procedures are performed in the two operating rooms reserved solely for that purpose. A separate wing of the hospital has been entirely devoted to caring for patients with cancer.

This hospital was particularly helpful during the clinical orientation of the College's first classes which had patient problem demonstrations as their initial contact with the College of Medicine. This contributed significantly toward their greater appreciation of the importance of the basic sciences in patient care. Both the hospital and its professional staff were most cooperative in these programs which were continued until the increasing size of our classes made it no longer possible for them to be held in the available space.

4. Women's Hospital

Women's Hospital is a private medical facility which opened its doors in November, 1974. Designed exclusive-



Tampa General Hospital



VA Hospital



St. Joseph's Hospital



Women's Hospital

ly to provide for the special needs of women in the Greater Tampa Bay area, the facility includes full obstetrical and gynecologic services and a pediatrics department. The hospital has 124 beds and 85 bassinets, and is staffed and equipped to provide the most advanced medical care for patients. It also offers many educational programs for patients such as prenatal classes, preoperative conferences and childbirth education.

Residents from the College's Department of Obstetrics and Gynecology are assigned rotations on a regular basis. Senior students enrolled in certain elective programs in Obstetrics and Gynecology receive all or part of their experience at Women's Hospital.

5. All Children's Hospital

All Children's Hospital is a community hospital located in St. Petersburg. It has beds for 100 patients, approximately one-half medical and one-half surgical, and a nursery for newborns. There are 16,000 outpatient visits per year. There is also a fully equipped eye clinic. Complete training is given in all aspects of pediatric ophthalmology.

This hospital, in both professional and administrative elements, has been genuinely interested in the

educational objectives of the College of Medicine. Consequently, this hospital has been extremely useful in the development of programs, especially in various pediatric areas and provides laboratories for research in pediatric endocrinology. In affiliation with the University of South Florida College of Medicine, programs are underway in Neurology, Gynecologic Endocrinology, Ophthalmology, Orthopedic Surgery, Pathology, Psychiatry, and Radiology.

6. Bayfront Medical Center

Bayfront Medical Center, formerly known as St. Petersburg Sanitarium, opened its doors in 1906. At that time, it consisted of 15 beds with seven physicians. It grew through the years and changed names several times, and in 1968 became known as Bayfront Medical Center. At this time it has 725 beds and a staff of 285 physicians. It also changed from a city operated to a private hospital with a new corporation, board of trustees, philosophy and policies.

College of Medicine students rotate through the Ob/Gyn service. It also has an active Family Practice residency which is affiliated with the Department of Family Practice at the USF College of Medicine.



All Children's Hospital



Bayfront Medical Center

Residency Training Programs

A major contribution of the College of Medicine to the Tampa Bay communities has been substantial improvement and expansion of the residency training programs. In its 10 years of existence and through its efforts, these have grown from but a handful of residencies in a few limited specialties, to a multi-hospital program including all major specialties. Currently 240 residents are in training in accredited programs.

The first fulltime clinical faculty arrived in Tampa in 1970 finding a number of residency programs in existence, some of which were on probationary status with Residency Review Committees. All residencies were supervised by volunteer physicians in private practice who, despite valiant efforts, were unable for various reasons to maintain full accreditation for a number of the programs. Arrival of the fulltime faculty culminated in successful efforts to increase the educational activities, to improve the clinical experiences of the residents and to bring all programs into compliance with national standards, which required that full time physicians supervise resident training.

Full approval was subsequently gained and has been maintained for all of the following training programs: Internal Medicine and its advanced subspecialty programs; Obstetrics and Gynecology; Ophthalmology; Pathology; Pediatrics; Psychiatry; Radiology; General Surgery; Otolaryngology; Orthopedics; Urology; Dermatology; and Neurology.

Planned for initiation in the near future are: Anesthesiology; Plastic Surgery; Thoracic Surgery; Cardiovascular Surgery; Neurosurgery and Child Psychiatry.

First Programs at Tampa General

Initial programs located at Tampa General Hospital included Internal Medicine, Obstetrics and Gynecology, Otolaryngology, Pathology, Pediatrics, Radiology, Surgery and Urology. The affiliation agreement between the College and the Hospital addressed the distribution and number of residents and the administration of the training programs. That affiliation continues in a modified

fashion at the current time. A separate affiliation agreement of a similar type was entered into with the St. Joseph's Hospital in a Psychiatric clinical training program and training for residents in Radiology and Pathology were instituted at that institution.

The Tampa Veterans Administration Hospital, established as a "Dean's Committee Hospital", was under construction during the early years of medical school operation and accepted its first patients in 1975. This made possible the installation of new residency programs which were also placed under direct control of the College of Medicine. These included Internal Medicine, Ophthalmology, Pathology, Psychiatry, Radiology, and Surgery. For these programs the hospital became a major training base.

Tampa General Hospital has evolved as the major residency training area for Pediatrics and Obstetrics and Gynecology and shares with the Veterans Administration Hospital Internal Medicine, Pathology, Radiology and Surgery.

The Psychiatry program has developed two major affiliations; one with the Northside Mental Health Center and the second with the Hillsborough Community Mental Health Center, both of which serve as bases for inpatient and outpatient psychiatric experience. Two other minor affiliations are currently in existence, one with Women's Hospital for obstetric training and one with All Children's Hospital for pediatric training.

Clinics Building Dedicated

In 1976, The Medical Clinics Building, the clinical facility on campus, built and designed to provide ambulatory services for the College of Medicine, was dedicated. It serves as a major ambulatory educational experience for residents and students in Pediatrics, Ob/Gyn, Family practice, Internal Medicine, Psychiatry, and many of the subspecialty areas. This facility provides a unique experience within the residency training program since it is one of the few free standing fee-for-service ambulatory care facilities in a university setting. Residents see scheduled patients, experience long-term

care and develop long-term relationships with patients.

All of the residency training programs are organized on a departmental basis with the Chairman of each department exercising control over faculty participation, program content, resident selection and maintaining program approval. The Medical Center is responsible for the central administration of the residencies but all of the didactic and educational experiences are departmentally controlled. The volunteer faculty continue to play a significant role in the educational mission in a number of residency programs, and they complement in a very important fashion, the talents of the full-time faculties.

House Officer Recruitment

The educational programs have developed in a fashion which provides a sound medical basis for each resident in training. Recruitment of house officers has been excellent and most of the programs have been

oversubscribed. The residents have been of high caliber and qualification, and have come from medical schools throughout the country. There are currently 240 residents in the program with growth having been steady since 1971. The house staff continues to be a dedicated group of young physicians willing to give of themselves and have been a delightful experience for most of the faculty involved. As they have completed their residency programs, many of these young physicians have established medical practices in the State of Florida. Each year approximately 50 percent of those who complete their residency program remain in the State of Florida to practice.

As can be seen from the above discussion, the residency program has grown steadily with the growth of the College of Medicine and has become an outstanding example of the type of residency program which can be developed by a college of medicine, and which provides a substantial community asset.



Surgical Residency at USF College of Medicine

James A. Christensen, M.D.

In the Spring of 1972, several months prior to becoming Chief Resident in a busy urban general surgical residency at Tampa General Hospital, I had a visit from Roger Sherman, M.D., a candidate for Chairman of the Department of Surgery at the University of South Florida College of Medicine. Following the meeting with Dr. Sherman, I was acutely aware that surgical education in Tampa would undergo a change.

After Dr. Sherman's appointment as Chairman, the already busy clinical service expanded with the construction of the new Veterans Administration Hospital. Soon after the first patients were admitted, two surgical residents arrived at the hospital to work and were surrounded by security guards, who had never seen or heard of a resident. For a short period of time, these residents were in jeopardy of arrest or expulsion from the building. Soon after this incident, the first surgical procedure at the Veterans Administration Hospital was performed by two of the faculty members. Everything was going well prior to the procedure, except in this multi-million dollar hospital there were no covers for the shoes, and these high ranking officials wore their stockings into the operating room.

Faculty Arrives

The arrival of a fulltime faculty brought a transition of our residencies to a "University Residency." Changes, of course, did not come about without conflict and a tremendous concern on the part of those of us entrenched in the residency prior to the arrival of the full-time faculty. The metamorphosis of this urban surgical residency to a university residency has been striking in the size of the residency staff, faculty and new buildings. Few could anticipate that the sand pile across the street from the Veterans Administration Hospital would become a medical school complete with full-service surgical department, and in many instances, offering surgical expertise that was not previously available.

The transition at Tampa General Hospital also did not go entirely smoothly. A raging debate between the administration of Tampa General Hospital and the



James A. Christensen, M.D.

Dr. Christensen was educated at Indiana University receiving both the A.B. and M.D. degrees from that institution. After completing his residency in General Surgery at Tampa General Hospital, Dr. Christensen joined the USF medical faculty as Instructor and then Assistant Professor, Department of Surgery. He was co-director of the new Burn Unit at Tampa General Hospital. Dr. Christensen is currently in the private practice of surgery and is Chief of the Surgical Staff at the new Town and Country Hospital in Tampa.

University over such interesting items as sleeping space for the residents, and long hours of debate regarding the feasibility of using bunk beds to increase the availability of "on-call quarters." With these great decisions behind us, we could move on to more meaningful achievements.

The achievements of the medical school include the development of one of the busiest surgical services in a Veterans Administration Hospital; the establishment of one of the three Burn Units in the state associated with a university; a Non-invasive Peripheral Vascular Laboratory and a Hand Service.

Visiting Professors

Visiting professors to the school have included such notables as Francis Moore, M.D., Robert Zollinger, M.D., William Altemeier, M.D., Harwell Wilson, M.D., William Scott, M.D., and Joseph Murray, M.D.

An Annual Suncoast Trauma Seminar has drawn more than 100 participants each year since its inception with a new group of distinguished guest lecturers on the program every year. The Department of Surgery has grown from one fulltime faculty member to faculty members in neurosurgery, cardiovascular surgery, peripheral vascular surgery, plastic surgery, pediatric surgery, urology, orthopedics and otolaryngology.

The surgical residents currently rotate through the Tampa General Hospital, which has a University Service, A Trauma Service, and a Pediatric Surgery Service. The Veterans Administration Hospital has very busy services, which include General Surgery, Peripheral Vascular Surgery, Chest Surgery, Open Heart Surgery, and Plastic Surgery. Where there was once only one Chief Surgical Resident, there are currently four Chief Residents. There are more than 300 applicants for the six first-year surgical residencies.

The next plateau of achievement for the Department of Surgery and the College of Medicine will be the completion of a university hospital adjacent to the medical school complex.

Interestingly enough, with all the previously mentioned changes and expansions, when I first arrived as a Surgical Resident in Tampa, any break available could be filled by fishing off the sea wall in Tampa Bay behind the Tampa General Hospital. Recently, while making rounds at Tampa General Hospital some 12 years later, I witnessed one of the residents catch a sizable snook from the sea wall. So, with all the changes that have taken place and will take place in the future, some things continue to remain the same, thank goodness!



Ph.D. Program in Basic Medical Sciences

In keeping with the development of a College of Medicine granting the M.D. degree, there is also the privilege and responsibility of educating students interested in the basic medical sciences who will earn Ph.D. degrees. These students will ultimately graduate and teach in preclinical sciences and conduct basic research.

The development of such a program was undertaken by an individual who was not only knowledgeable in the basic sciences, but who also was a highly competent investigator. The responsibility for development of such a program was undertaken by Charles W. Fishel, Ph.D. (now deceased).

Dr. Fishel, a member of the Charter Faculty, was Professor and Chairman of the Department of Medical Microbiology from 1970 through 1978. He was an eminently renowned researcher whose specialty was immunology.

On February 5, 1973, during a five year moratorium on development of new Ph.D. programs in the State (from 1970 to 1975), a "Planning Authorization Request for New Degree Programs", at the University of South Florida College of Medicine was submitted by the College that would lead to the Doctor of Philosophy Degree in the Sciences Basic to Medicine. The program proposal was submitted May 1, 1973 and the proposed starting date of the program was January 1, 1974. In September, 1974, a memorandum was sent by the Dean to the Basic Science Chairmen announcing that the Board of Regents had recognized the necessity of such a program and approved initiation of the proposed Ph.D. program at the College of Medicine.

Combined Participation

The following is a brief description of the program and its justification. The application sought permission to plan a graduate program leading to the Doctor of Philosophy degree in Medical Sciences. The proposed program involved the combined participation of the Departments of Anatomy, Biochemistry, Medical Microbiology, Pathology, Pharmacology/Therapeutics, and

Physiology of the College of Medicine, University of South Florida. The type of graduate program now offered consists essentially of two phases followed by specialized training.

After fulfilling entrance requirements, the student enters the first phase where training in all the basic medical sciences is emphasized. Core Courses in Anatomy, Biochemistry, Medical Microbiology, Pathology, Pharmacology/Therapeutics, and Physiology are offered. These courses extend over a 9-month period with one-half of the students' time devoted to these subjects. The other half-time during this period is flexible and tailored to individual needs. At the conclusion of this phase, each student is required to successfully complete a qualifying examination (written and/or oral) covering the material presented in the "core" courses as well as general scientific knowledge. Faculty of all participating departments are represented in the examination process.

Second Phase

The second phase of the program involves additional course work. The courses selected are directed toward a more specialized area considered by the student in concert with an advisory committee. The student gains through time spent in the laboratory, experience in problem solving and the operational significance of instrumentation. The student may audit courses involving medical students and participate to some degree, in the planning and preparation of laboratory sessions. At the conclusion of this phase, the individual is in a position to select the appropriate area of interest for investigational endeavors. The student is also required to fulfill two foreign language requirements or acceptable substitute courses.

After satisfactory completion of the qualifying examination and the foreign language requirements, the successful student is admitted to candidacy for the Ph.D. degree. At this point, research leading to an acceptable dissertation is undertaken. The written dissertation must be of high standard and contribute new information to the scientific community. The final event in the program

is the oral defense of the dissertation.

A standing committee advises the student throughout each phase of this program. As the field of major interest develops, the student's advisory committee is appointed accordingly.

Justification for Program

A major justification for initiation of a graduate program in the medical school may be found in a statement of the Council on Medical Education of the American Medical Association. As pointed out in the statement, the expressed concepts serve as one of the criteria utilized in the medical school accreditation process.

The Council states, "A medical school has four inherent responsibilities which embody the concept of a continuum of education throughout professional life. The first is to provide its undergraduate medical students a sound basic education in medicine."

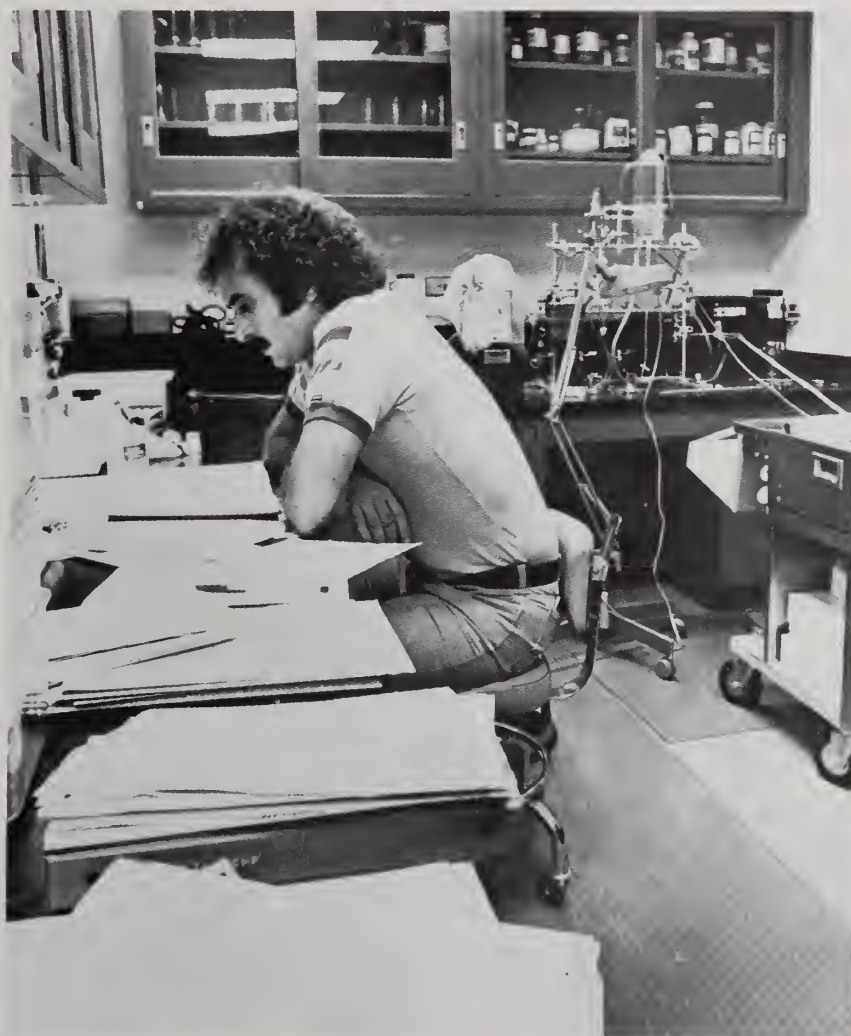
The second responsibility is, "A medical school is

responsible for the advancement of knowledge through research." This emphasizes the need of research interests in our faculty.

The third stated responsibility is particularly appropriate to the establishment of the graduate program in medical science, "Each school is responsible for development of graduate education both to provide models for better care of patients through clinical residency programs and to contribute to the development of teachers and investigators through advanced degree programs in the basic medical sciences."

The fourth area of responsibility concerns the conduct of continuing medical education.

The Ph.D. program has undergone some changes and further developments have been instituted. The basic tenets of the program have remained unchanged. Currently, the College has a total of 23 graduate students at the Ph.D. level. Since implementation of the program, 10 students have received the Ph.D. degree in the Sciences Basic to Medicine.



The Mace

In the Spring of 1972, a few months after the admission of the Charter Class, the idea of a ceremonial Mace to be used in commencement exercises, began to germinate among certain members of the small initial faculty of the College of Medicine. The Mace originated with the spontaneous interest of the ultimate members of the committee who were officially appointed in the Spring of 1971. The committee was composed of three members of the Faculty; Drs. Jack W. Hickman, James M. Ingram and Rudolf J. Noer.

The prime requisites for the creation of a Mace were the location and acquisition of a piece of wood of genuine significance in the history of medicine in Florida. Logically, the search began at St. Augustine, where the Spanish, under Governor Gonzalo Mendez de Canzo, built the first hospital in North America in 1598. This hospital, like most of its early successors, was constructed adjacent to or against the wall of the existing cathedral. As both cathedral and hospital were either moved or rebuilt, their coquina rock foundations were abandoned, and the thick wooden beams were used again and again in newer structures.

Through the efforts and kindness of James J. DeVito, M.D., then of St. Augustine, one of the massive oaken beams was found. It could be traced from the period 1763-1784, when the English used old Spanish hospital buildings during recurring epidemics of yellow fever. Some time afterward, it was moved and used in the construction of St. Augustine Cathedral, where it remained until the Cathedral was partially destroyed by the great fire of 1860. The beam was salvaged and was made a prominent part of the old Lyceum, an auditorium of the Sisters of St. Joseph's Convent.

When the Lyceum was partially torn down, over a century later, in 1971-72, the beam was acquired by architect Boyd Parker of St. Augustine. Upon learning of the search by the Mace Committee, Mr. Parker graciously presented the beam to the College of Medicine in June 1972.

The rectangular beam measured five feet, four inches

in length, nine inches in diameter, and weighed 157 pounds. It contained one square notch and seven large drilled holes, three of which were plugged with two-inch wide, hand whittled pegs. When examined by two-



The Mace

dimensional X-ray, several thick, square, hand-forged iron nails, with heads rusted off, were found imbedded in the wood, and were removed. The beam was then sawed longitudinally into four posts, the best of which was reserved for the Mace.

The absolute clarity of the grain, and the nature and size of the iron and dowel fittings, led wood experts in Tampa to conclude that the beam originally had been a part of the keel or rib of a sailing ship. The density and extreme hardness of the oak indicated it had been felled in latitudes far north of Florida, which for Spanish shipbuilding of the 16th Century, would have been in Europe.

After considerable search, a rare combination of both artist and artisan was found to create the Mace from this historic wood. Graduate Art student, Stephen Estes, of the University of South Florida, was asked to submit full scale designs, and then was commissioned in early 1974 to construct the Mace from the oak and from hand-wrought, bulk silver and gold. Both the design and building of the Mace was done by Mr. Estes on the campus of the University of South Florida.

Originally the Mace was a weapon, in more recent times a ritual object symbolizing authority. Its form is derived from man's ritualistic ornamentation of objects,

carried through in this instance in the silver, gold and wood, hand-wrought and forged. There is no part of our Mace which does not have or represent a functional purpose; its hammered surface reveals the process of fabrication. The nails are exactly what they are: nails or rivets. The ribs' actual construction is reminiscent of buttresses (structural elements) which provided simple means for attaching four quarters to make a substantial sphere. The traditional staff of Aesculapius, God of Medicine, with its single entwined serpent, for centuries associated alike with medicine and wisdom, together with the seals of the University of South Florida and of its College of Medicine, complete the symbolism specific to this institution.

Financing of the Mace was made possible through contributions of the fulltime and clinical faculty, and through the generous support of Dean Donn L. Smith. Totally fabricated on this campus, the Mace was completed only during the night before the first commencement and delivered but an hour before the beginning of that ceremony. It was thus carried in the procession at graduation of the Charter Class in December of 1974 and has continued to provide a colorful element in every subsequent commencement at this College of Medicine.



The Fulltime Faculty

The faculty, more than any other single factor, determines the effectiveness of every educational undertaking. Jaques Barzun pointed out many years ago that "the virtues which we hope to instill in the minds of our students comes not from a course, but from a teacher; not from a curriculum, but from a human soul." Nowhere is this statement more truly applicable than in a college of medicine.

The fledgling school at the University of South Florida was fortunate to have the leadership that was responsible for assembling the nucleus of its teaching staff. The President of the University at that time was not only an experienced educational administrator, but an astronomer and scientist in his own right. The founding Dean was qualified not only in clinical medicine but in basic science as well, and with extensive administrative experience in two well recognized colleges of medicine.

The initial faculty appointees were chiefly in the basic medical science areas at the time the College opened. This was, of course, the logical sequence since the first year was to be devoted almost exclusively to the basic sciences. When the Charter Class enrolled, the Anatomy Department was the first "giant" because it had three fulltime members! Additional basic science faculty was added as the year proceeded, again largely in the basic disciplines because of curricular demands. Demonstrated competence in one's academic discipline and recognized teaching ability were and continue to be the primary requisites for faculty appointment. Research talents of necessity had to remain inchoate during the formative stages, but as the institution grew in size and scope, of course greater attention could be given to research potential than had been the case with initial appointments.

There were but four clinicians present on the fulltime faculty when the Charter Class arrived, representing Internal Medicine, Surgery, Obstetrics/Gynecology, and Psychiatry. Since the only clinical exercises were those of a correlative nature, these individuals were able to provide clinical conferences aimed at enriching basic science comprehension and assimilation, but those

courses required extensive use of the voluntary faculty. These practitioners participating for the joy of teaching and association with the young neophytes provided invaluable assistance which has continued to be the case throughout subsequent years as well. (See separate section on voluntary faculty).

Growth of the fulltime faculty rivaled that of the physical plant of the new College of Medicine during the early years. As the other basic science departments began to catch up with Anatomy, recruitment was getting underway for clinical departmental chairmen. Obstetrics/Gynecology and Psychiatry were included in the Charter Faculty and these were soon joined by other clinical chairmen.

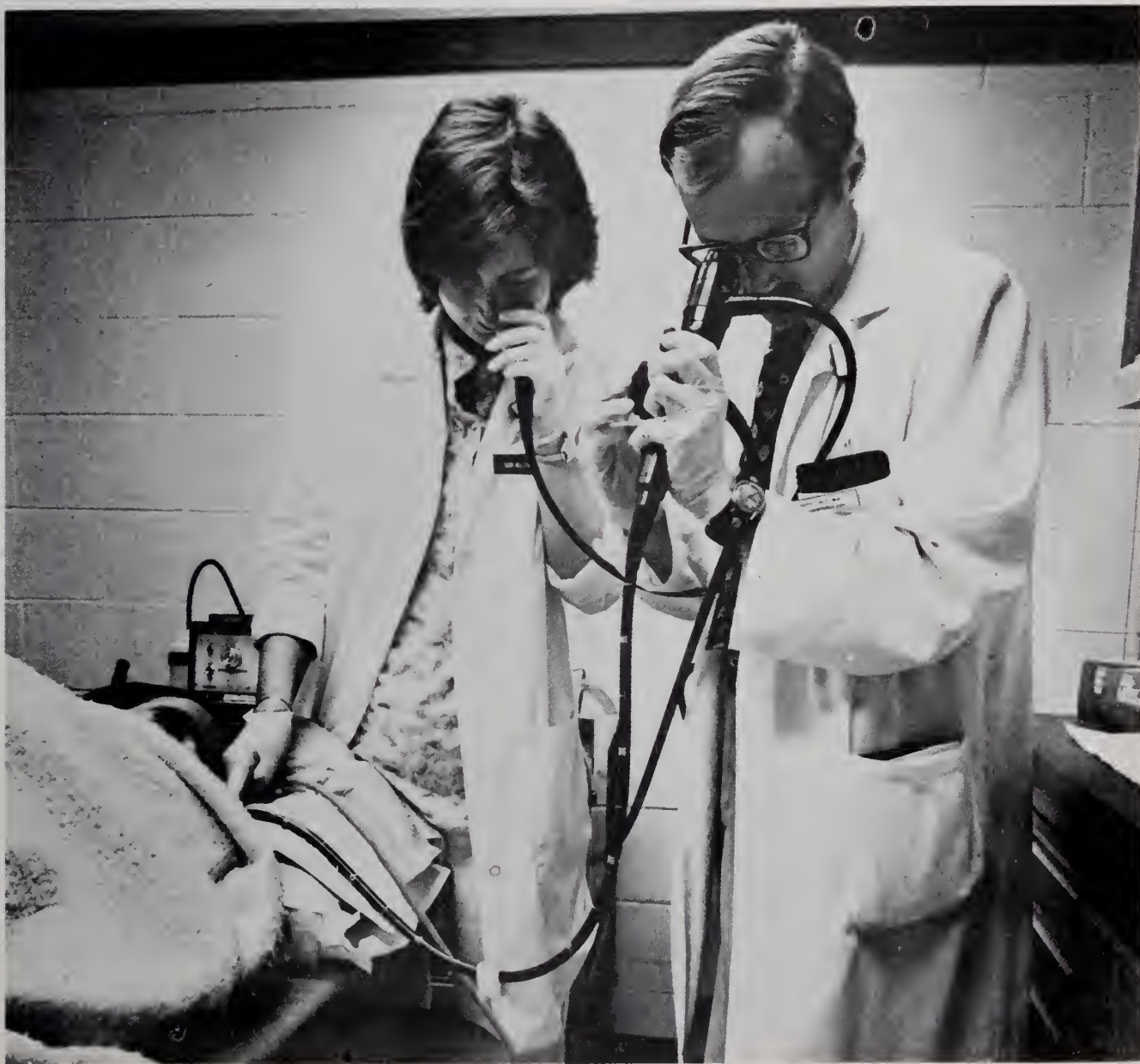
We have been extremely fortunate to have four of five major clinical chairmen still functioning in the positions they accepted some eight or nine years ago. Anticipated difficulty in recruitment of clinicians of stature failed to materialize for we were fortunate in having several advantages at the outset. First of all, the challenge of a new school unhampered by departmental conflicts and jealousies and without vested departmental interests was in itself a welcome contrast for many accustomed to such problems elsewhere. Further, the challenge of a group of well qualified new students in such small numbers as to permit individual faculty-student contact in abundance was a real attraction for dedicated medical educators. Strong leadership at both university and college level, a growing university situated in the midst of the climatic attractions of the Florida area all combined to make the positions desirable. All departments were adequately staffed by the time the Charter Class reached its first clinical assignments.

Diversity of background and experience has been one of the strengths of this developing institution. At present, approximately 200 fulltime faculty have come from a total of 70 United States medical schools and a number come from those of other countries. Two members of the fulltime faculty hold both the M.D. and Ph.D. degrees and several enjoy national and international reputations in their fields. The widespread differences

in background have not always made for smooth or non-controversial faculty meetings and academic decisions; they have, on the other hand, been invaluable in minimizing the provincialism so often exerting an unfavorable influence upon the planning and course of some of the older institutions.

The only loss which has taken place during the spectacular growth of our faculty has been that of close personal relationships, with each and every member of the faculty knowing the other. The first years' experience with the Charter Class was unique for both faculty and students with a faculty/student ratio almost one to one. It was a joy to participate in such an informal and intimate learning process which has unavoidably been lost as the

class size gradually rose to 36, 64, 74 and now 96 members. During this same time, the faculty membership as previously mentioned has been multiplied many times as well. No longer can the entire faculty be called together for a meeting within five or ten minutes. We are fortunate, however, in that no "iron curtain" has appeared between clinical and basic science departments. One can still see surgeons, internists and other clinicians having lunch with biochemists, anatomists, and other basic scientists. However, we are now at a point where one may not know all of his colleagues in some of the largest departments. This, of course, is not unique to our College. It is only an inevitable and regrettable fact that with growth and increasing sub-specialization it had to be.



The Change of Life at 50

James M. Ingram, M.D.

Some major decisions of life are made by ponderous planning, while others are simply the result of coincidence of time and place. The latter was the case in my change of career, at the age of 50, from private practice into academic medicine.

There had always been a deeply gratifying interest in voluntary teaching, both in the OB/GYN residency training program at Tampa General Hospital and on the clinical faculty of Dr. Harry Prystowsky's department at Gainesville. A busy practice had afforded ample opportunity to investigate and to publish. Experience had been gained in 20 years of representing the Admissions Committee of Duke Medical School in North Carolina. Nonetheless, the major thrust of life had been private practice, and it was a very happy and satisfactory one at that.

Oddly enough, the train of events leading to the change of career began four years before the opening of the USF medical school, when the Hillsborough County Medical Association decided to rewrite its constitution and by-laws. In order to conform to the business year of the new constitution, one HCMA President would have to serve for a long term of two years. As a result, there was a considerable amount of jostling between the attorneys drafting the constitution by the incumbent President, my former resident, Dr. Henry Wright and myself as President-Elect. As usual, it was impossible to buck the incumbent. Dr. Wright was able to speed up the process of revision, and I was left with the dubious honor of a two-year term in 1969-70.

Two Formative Years

These turned out to be the two formative years marking the birth of the USF College of Medicine. In 1969, USF President John Allen asked several physicians in the community, including myself as HCMA President, to serve on the search committee for the founding Dean. It was obvious that, of necessity, the choice would be made by President Allen and the Regents, and that the position and function of the local physicians was quite peripheral. Nevertheless, it was a fascinating privilege to be even near the vortex of this historic activity. A number



James M. Ingram, M.D.

Dr. Ingram, M.D., is a native of Tampa. He is a graduate of Duke University and the Duke University School of Medicine. After a successful career in private practice in Tampa, Dr. Ingram was appointed to the Chair in Obstetrics and Gynecology at the USF College of Medicine as a member of the Charter Faculty, a position which he still holds. Dr. Ingram has served as President of the Hillsborough County Medical Association, the Florida Obstetric & Gynecological Society, and the Continental Gynecological Society. Dr. Ingram received the Distinguished Alumnus Award from the Duke University Medical Center in 1976.

of highly qualified candidates were interviewed. Donn L. Smith, M.D., Ph.D., was appointed as founding Dean and took office on January 1, 1970.

For some time before the official date, there had been considerable communication and interface between the Dean-designate and the HCMA, as the medical school would require affiliation both with clinical faculty and with the hospitals in Tampa. My duties with HCMA led to frequent and productive contact with the Dean.

A Job Is Offered

He was invited by the FMA to participate in the Presidents and Secretaries Conference at the Robert Meyer Hotel in Orlando, January 31, 1970. At the conclusion of the conference, the Dean suggested that the two of us drop by the hotel bar before having dinner with the officers of FMA. Just after ordering, the Dean quietly and briefly invited me to become Chairman of the Department of Obstetrics and Gynecology. I nearly fell off my stool, even though the refreshments had not yet arrived. There had been hopes of teaching in some capacity with the school, but the chairmanship was a bit overwhelming. I asked for a month to think it over and to evaluate the drastic family budget revision that would be required. After a number of evenings of discussion and planning with Liz, the decision was reached to change the *modus vitae* for both of us, 10 months later, on January 1, 1971.

Even though it had been carefully planned, the change was abrupt, and sometimes harsh. There were only 10 of us on the charter faculty, of which three were in clinical medicine. The tasks that lay before this small group were monumental. There were faculty to be recruited, buildings to be designed, hospital affiliations to be negotiated, library books to be acquired, and students to be admitted, just to name a few.

The 70-Hour Week

Most of this lay far afield from the practice and teaching of my specialty. Each of us had to perform the duties assigned, often sharing or exchanging jobs. The 70-hour week was routine for everyone. A deep and lasting camaraderie developed quickly between the few members of the charter faculty.

Other unforeseen and somewhat foreign duties appeared. The Dean was convinced, and rightfully so, that the acoustics of most medical school auditoriums were abominable. Several of us were assigned the task of inspecting and evaluating the auditorium on any trip that we made away, and some short trips were made for the purpose of evaluation alone. It paid off handsomely in the end, as our four lecture amphitheaters and one auditorium have perfect acoustics. But for a gynecologist, it was a complex path from round oviducts to square

feet to rebounding decibels.

The greatest adjustment for me was in the area of patient care, which had been the dominant activity of all of my adult life. This, the *raison d'être* of the private practitioner, had to be assigned equal priority with teaching, administration, and clinical research.

No Clinical Facilities

There were no clinical facilities in the medical school and no other practicing clinicians in the earliest charter faculty. Thanks to the great generosity of my former partners, and with the Dean's approval, a portion of each week could be spent in my former office to see patients. It would be nine months before space was obtained at 1 Davis Boulevard for faculty practice, and 14 months before my administrative office near Tampa General Hospital was available. Sometimes, it was like living out of a suitcase.

The transfer of the majority of my patients to partners and colleagues was an emotional experience, particularly as concerned the long-term oncology patients from my 20 years of practice.

Another major problem was the change from self employment, even though in a partnership, to being employed. Except for duty as a medical officer in World War II, self-employment had been the rule. The free and independent life of the self-employed was suddenly traded for the role of an employee of the State. On the surface, this might not appear to be highly significant, but the ramifications were many. This problem was resolved only by a gradual alteration of approach on my part.

The Institutional Life

The constrictions and complexity of institutional and bureaucratic life were a similar matter. In private life, an objective can be defined and pursued, traveling from point A to point B with only the foibles of human nature lying in the path of progress. Not so in academia; at almost every movement forward a half dozen or more regulations, endless forms, guidelines, or economic restrictions seem to appear to impede action or progress. At times, it was like walking in the lower Everglades, one step forward, then slipping back half the distance. Further mental adjustment and personal discipline was required to live with this problem.

In the warp and woof of all these activities, there was so much for a clinician turned academician to learn. Teaching an assigned subject of a curriculum was entirely different from designing a departmental curriculum, and then, in turn, blending this into the total medical school curriculum. Potential faculty of every conceivable quality passed through. Evaluation was usually difficult. Who could teach? Who could work in harness with other faculty? Who would stay? Who would come for the

compensation afforded? The State wage freeze came and much of the new faculty went. In essence, the Department had to be built twice in the first seven years. There were more than a few sleepless nights before the Department reached its current status at the 10-year mark.

Private Practice vs. Academia

Throughout all of this, there was one facet which is still only partially understandable. So many of my medical colleagues and close friends outside medicine have regarded the move to academia as somewhat of a change, but primarily as a marked slowing of the pace of life, and even congratulations have been offered along these lines. There are now 20 years of private practice to compare with 10 years of academia. My strong personal conviction is that, if one's maximum effort is devoted either to private practice or to academic medicine, then the academic medicine will prove far more demanding of time, effort and family.

On the positive side of the ledger, there have been far more than enough compensating factors. The people of academia proved to be much more cordial and supportive than ever anticipated by a newcomer. My own sense of personal inferiority to colleagues who had spent their entire careers in academic medicine was self-evident, and occasionally intense and it would only be hoped was not too obvious to those at hand. My fellow chairmen had every right to question why I was there, yet, with rare exception, they were supportive and offered genuine friendship.

Advice and Support

The interest, sound advice, and support that came in from academicians around the country, and especially from my colleagues at Duke, can never be adequately acknowledged and never forgotten. Dr. Roy Parker, my fellow resident at Duke, who returned from private practice to Duke, eventually becoming Chairman, wrote in his congratulatory letter at the time of my

appointment—"There will be many times in the first five years when you will wonder and regret why you ever left private practice. When these moments come, just hang on and keep pushing forward." How right he was. One of the greatest compensations of the last decade has been the association and friendship, both old and new, with fellow teachers.

But, by far the greatest reward has been the privilege of association with those younger than ourselves; the students, residents and more junior faculty. The teaching, counseling, molding, and just simple daily conversation with young people has been infinitely satisfying, and has, within itself, been more than worth all of the effort and frustration. The education of residents must surely be one of the most rewarding experiences allotted to mankind. Though it involves discipline, the training of residents, in my view, is a family affair which lives long after the process is completed. Our large and growing resident family means equally as much to me as my own blood children. Perhaps the greatest moment of my career to date in the medical school came in December, 1980, when two members of the Charter Class, trained here in our USF Residency Program, Dr. Lindsay Struthers and Dr. Randy Armstrong, were certified by the American Board of Obstetrics and Gynecology. Both the school and we had come of intellectual age.

One final, and perhaps less important, compensation must be included. It has been my role for the first 10 years of the school, to be the only Tampa native, now in the fourth generation, to serve both on the charter faculty and as a departmental chairman. In these years, the College of Medicine has evolved from a bare piece of Florida scrub oak real estate into a respected and productive medical school. The birth and maturity of the school is most certainly gratifying to all concerned. But to Liz and me, both natives, the creation of the medical school, right here in our own home, *must* have just a bit deeper meaning.

MEDICAL SCHOOL ORGANIZATION

Director of the Medical Center
and Dean of the College of Medicine
Andor Szentivanyi, M.D.

Department

Anatomy
Biochemistry
Comprehensive Medicine
Family Medicine
Internal Medicine
Microbiology
Obstetrics/Gynecology
Ophthalmology
Pathology
Pediatrics
Pharmacology/Therapeutics
Physiology
Psychiatry
Radiology
Surgery

Chairperson

Johannes A. G. Rhodin, M.D., Ph.D.
Joseph G. Cory, Ph.D.
William A. Sodeman, Jr., M.D.
Charles E. Aucremann, M.D.
Roy H. Behnke, M.D.
Herman Friedman, Ph.D.
James M. Ingram, M.D.
William E. Layden, M.D.
John U. Balis, M.D. (Acting)
Lewis A. Barness, M.D.
Andor Szentivanyi, M.D.
Carleton H. Baker, Ph.D.
Anthony Reading, M.D.
Arthur D. Graham, M.D.
Roger T. Sherman, M.D.

Clinical (Volunteer) Faculty

Medicine has enjoyed a long tradition of teaching since before the admonition of the familiar oath of Hippocrates: "... to impart a knowledge of this art to my sons and to those of my teachers, if they should wish to learn it, without fee or stipulation..." It is but a step from the apprenticeship of those early days to the clinical faculties of today.

Basic medical sciences were well staffed when the charter class arrived, but only four clinicians were on the faculty at that time. Clinical orientation, described in the section on curriculum and planned for the first two weeks of class, required extensive participation by voluntary faculty for this, as for other correlative exercises scheduled for later in the students' experience. Members of the professional staffs of Tampa General Hospital and St. Joseph's Hospital proved to be interested and most cooperative in these clinical demonstrations for the charter class. They thus provided essential faculty support during the early months and years, while they laid invaluable groundwork for the future participation of practicing physicians in the continuing growth and development of our academic programs.

Voluntary Teaching Valuable

Fortunately, those physicians who wish to be professors but are reluctant to profess are in the minority; most of those primarily in practice are glad to embrace the opportunity of aiding in the instruction of those soon to follow them in the art. Medical educators are in general agreement that the voluntary participation of private practitioners in instructional programs provides a valuable balance with those devoted primarily to academic careers—that the "mix" provides a wholesome balance in the instructional programs.

The College of Medicine and its early classes owe a substantial debt to those staff members of the Tampa General Hospital and St. Joseph's Hospital who freely gave their expertise and time with scant tangible recognition in the beginning exercises. As the programs developed, and with the advent of permanent clinical chairmen, appointments were made on a more formal basis. Academic ranks and appropriate progression therein became the rule, providing more appropriate

recognition of the individuals' contributions. The first bulletin of the University of South Florida College of Medicine listed fifteen faculty members, of which but two were in the "clinical" (i.e. volunteer) status; the second bulletin included 14 volunteers among a total of 40 faculty. The present total clinical faculty numbers approximately 642.

Present Volunteer Faculty

The present-day clinical faculty are selected for the most part by department chairmen and the fulltime faculty of the various specialty departments. Almost all are board certified in their specialties and are selected on the basis of their desirability and willingness to teach medical students and residents either in a clinical or classroom setting. They devote their time and effort on a voluntary basis and work closely with the fulltime faculty within the teaching framework of the curriculum. Many members of the clinical faculty have made significant contributions in their respective specialty fields and are currently engaged in on-going research projects in conjunction with the students, residents and faculty of the College of Medicine. Many of the departments of the College rely on the clinical faculty to help integrate teaching programs by exposing residents and students to the private sector of medicine. Students and residents spend varying amounts of time in select private hospitals in the geographical area working with the clinical faculty in the care of the private patient. Thus, students and residents have exposure to members of the profession who practice in different settings.

Elective Time

Some clinical faculty members have set up programs whereby a senior medical student can spend one to two months of elective time working within the framework of that individual's private practice. This elective program has served as an enlightening and rewarding experience for the senior medical student contemplating a career in a particular specialty field.

The Clinical Faculties of the College of Medicine of the University of South Florida are to be saluted for their voluntary contributions to the education of the future physicians of this State.

Special Clinical Programs

As the University of South Florida College of Medicine grew over this past decade, the areas of special medical expertise represented in the faculty have increased proportionately. The major faculty efforts were devoted initially to the establishment of the curriculum, development of approved residency programs, and primarily to the educational responsibilities of the institution.

However, in time, specialized clinical functions began to develop, albeit slowly at first. Now, a decade later, these programs are growing at a more rapid rate, and some of the earlier programs are well accepted by patients and physicians alike.

Some of the following programs were developed almost entirely by the singular efforts of one faculty member, whereas others are cooperative ventures of inter-departmental effort. Others have required the participation of departments from other colleges within the University of South Florida, governmental agencies, the practicing community, voluntary health agencies, hospital governing groups and interested citizens.

Diabetes Center

In 1979, Florida became the first state in the nation to establish a funded diabetes education, treatment and research program. Recognizing the profound physical and economic impact of this disease, the Legislature in 1976 enacted legislation to fund three Diabetes Centers at the medical schools in Tampa, Gainesville, and Miami.

The University of South Florida Diabetes Center serves an 18-county area extending southward to Collier County and eastward to Brevard County. The prime objective is diabetes education for patients, their relatives and the professionals caring for them. At USF, this is carried out in two ways: (1) The establishment of a model care clinic at the USF Medical Clinics for education of patients, relatives and professionals and (2) The establishment of an outreach program for diabetes education in the health facilities and hospitals of the 18-county area. Educational tools are developed, tested and distributed in order to meet these needs while seminars including five-day programs and lecture sessions are being held in Tampa and throughout the area.

At the USF Medical Center, diabetes treatment is provided by physicians in the referral center which accepts patients with difficult problems associated with diabetes. Specialists in pediatric and adult diabetes management are available. Patients are accepted by physician referral and a 24-hour hot-line for advice on either pediatric or adult diabetes is offered to physicians. The most up-to-date equipment for management and evaluation of patients is available including an artificial pancreas, insulin infusion pumps, computer assisted education, portable glucose analysis, etc.

Outreach pediatric clinics sponsored by Children's Medical Services are operated by the staff of the Pediatric Diabetes Program in Lakeland and St. Petersburg. They provide primary care for Children's Medical Services eligible children and mini-courses in diabetes home management for families and Health and Rehabilitative Services medical personnel in those areas.

Tampa Area Hospital Infection Control Program

Six hospitals in Tampa and one in Sarasota have formed a consortium for infection control. The goal is to lower hospital infection rates by achieving a uniform high quality standard for infection control practices in the hospitals. Each hospital employs its own infection control team including nurses and clerical personnel. Professional consultation is provided by faculty members. Regularly scheduled consultation visits incorporating the review of data concerning hospital infections, resolution of infection control problems, planning of educational programs, on-site visits to areas within the hospitals, and presentation of formal lectures and programs are conducted by the faculty of the Division of Infectious Diseases of the College of Medicine.

The program, begun under the sponsorship of Florida Regional Medical Programs in 1973, is self-supporting. Besides accomplishing a significant reduction in most types of hospital acquired infections in the participating hospitals, the program has provided the impetus for creation of a local chapter of the National Association for Practitioners in Infection Control. Members of the consortium have developed and

presented numerous regional education programs, and a unique home-study course for basic training of infection control nurses. This education program is now being used by dozens of infection control nurses throughout Florida and the southeastern United States.

Transplantation Immunology Laboratory

The Transplantation Immunology Laboratory, under the direction of the USF College of Medicine Renal Service, provides histocompatibility testing (tissue typing) services for patients of the Tampa Bay Area and the West Coast of Florida. These procedures include: Definition of HLA locus A, B, C, and DR antigens; compatibility/disparity at HLA-D as determined by reactivity in mixed leukocyte culture; analysis of sera for the presence and specificity of lymphocytotoxic antibodies; and lymphocytotoxic antibody cross-matching. Results from these tests are used to select donor-recipient pairs for kidney and bone marrow transplantation.

Kidneys for transplantation are shared with other medical centers across the country by our participation in a regional and national computer matching program. Methods for immunological monitoring of patients post-transplant are being established in the laboratory and include assays for cellular mediated cytotoxicity, antibody dependent cellular cytotoxicity, cytotoxic and blocking antibodies, and immune complexes. The immunological status of patients is assessed by the quantitation of T dependent lymphocytes and their proliferative response in culture upon challenge with mitogens, specific antigens, and allogenic cells. HLA testing is also offered for disease correlation studies and paternity testing.

Gastroenterology Center

In January, 1977, a new 1,100-square foot, six-room facility called the L. M. Hughey Gastroenterology Center was dedicated at Tampa General Hospital. Through strong support from the private community, the hospital auxiliary, the hospital and the medical school, special equipment, totalling more than \$200,000 was purchased.

This new facility, which is a model in the Southeast, contains offices for a fulltime staff of three gastroenterology assistants, attending physicians, a laboratory for gastrointestinal secretions and three specialized rooms for various diagnostic and therapeutic gastrointestinal procedures. The center also contains a fluoroscopy unit which is operated independently from the main x-ray department. The center was instrumental in introducing various new procedures to the area such as colonoscopy and polypectomy, laparoscopy, ERCP, endoscopic sphincterotomy, endoesophageal prosthesis and others. The attending staff has grown from the initial five

founding members to 19 at present. The number of procedures has steadily increased and now exceeds 1,200 per year.

All facilities are jointly utilized by private and university gastroenterologists. A regular postgraduate conference schedule has integrated various disciplines involved in the diagnosis and treatment of digestive diseases and nutrition with attendance and active participation by physicians from the Tampa Bay Area and surrounding counties. The Division of Gastroenterology and the Gastroenterology Center at Tampa General Hospital cooperation is an example of the development of new facilities and services initiated by the College of Medicine and harmoniously integrated into the practicing community.

Eye Bank

An early and important community service was initiated by the Department of Ophthalmology. In concert with the local Lions Club, an eye bank was founded and named the Lions Eye Bank. Over the succeeding years, 1,966 eyes have been given to the eye bank, of which 258 have been prepared for corneal transplants. A total of 257 corneal transplants have been performed by the departmental faculty. The merits of this program are quite obvious, and the Department and the College are indeed grateful for having the opportunity to provide this important humanistic service for our community.

Ophthalmology Microbiology Laboratory

The Department of Ophthalmology maintains a microbiology laboratory in order to perform cultures on patients who are referred to the University with serious infectious ocular diseases. To date, over 6,000 eye cultures have been performed on a variety of serious ocular infections. While most cultures have been performed for conjunctivitis and blepharitis, over 350 corneal ulcers and over 50 cases of endophthalmitis have been evaluated microbiologically.

Ocular Pathology Laboratory

The Ocular Pathology Laboratory is an integral part of the Department of Ophthalmology. The Laboratory provides diagnostic and consultative services to ophthalmologists and pathologists in the area. Whole specimens or slides are frequently sent to the Laboratory for gross and microscopic description and/or for consultation regarding the diagnosis and treatment. Reports and slides are sent to an ophthalmologist and/or pathologist. Many diagnostic biopsies are sent directly to the Laboratory from local ophthalmologists.

An additional function of the Ocular Pathology Laboratory is the education of medical students and residents in Ophthalmology and Pathology. Over the

years, a number of interesting specimens have been received in the Laboratory and selected specimens have been placed in the teaching files for their value for gross pathological changes.

Neonatal Intensive Care Unit

Modern neonatal intensive care was brought to the Southwest Florida area in late 1972 by faculty of the University of South Florida College of Medicine. The teaching program opened a new facility December 13, 1973 at Tampa General Hospital for the care of 14 critically ill neonates as well as seven recuperative beds. During the first year of operation under the supervision of a single faculty member, approximately 650 ill newborns entered this service. As concepts of neonatal ventilation and care rapidly demonstrated their clinical application, a significant service to the community was evidenced by diminished newborn mortality and morbidity.

The program has grown to be the second largest program in the State of Florida with the addition of additional fulltime faculty and currently serves as a major teaching resource for the Department of Pediatrics at the College of Medicine. Recent advances and additions with the specialist in maternal-fetal medicine have produced rapid escalation in the number of deliveries at Tampa General Hospital. The transfer of mothers on behalf of the fetus in utero for neonatal intensive care has become a clinical care program for the community. Nine investigational protocols for the development of academic new information related to patient care are in use at this teaching unit.

Perinatology Center

A new perinatology center is being constructed at Tampa General Hospital with state funds. It is accessible by various modes of transportation, including helicopter. The service area for the Tampa General Hospital/College of Medicine Maternal-Fetal Medicine Service will encompass approximately 25,000 to 30,000 deliveries within the next five years. The new center will have capabilities for handling 4,500 deliveries within the intensive care nursery and obstetrical suite.

Within the obstetrical suite there will be one room for cesarean sections, six delivery rooms, a maternal-fetal intensive care unit for eight mothers at risk, and a new neonatal center. The importance of intensive continuous monitoring of mother, fetus and newborn has been emphasized in the design. The Maternal-Fetal Intensive Care unit incorporates eight beds in a glass enclosure along one wall of an open unit. This concept allows optimal nursing surveillance with a reasonable degree of privacy. The recovery room for the mothers will be operated so that there will be the ability for

intensive post-partum care; however, the accessibility of the existing adult intensive care units, including respiratory, cardiac and intermediary intensive care, remains a luxury which we presently enjoy.

In addition, the low risk patient will be allowed to deliver in the "birthing rooms." These birthing rooms will be constructed and designed so that a relaxed "home setting" may be effected. Support for the mother will be engendered by the husband and the nursing staff. In addition, two clinical perinatal nurse specialists will be available to assist these patients and also those who are at high risk.

Child Development and Behavior Clinic

The Child Development and Behavior Clinic meets weekly to evaluate problems of normal children; to diagnose, evaluate and treat school problems; and to counsel parents of children with chronic illnesses. The clinic consists of three pediatric faculty members, a family therapist, and a psychologist trained in evaluation of learning disabilities.

Pediatric Metabolic Disease Laboratory

The Metabolic Disease Section of the Department of Pediatrics at the University of South Florida provides the metabolic diagnosis, medical management and follow-up for many of the inborn errors of metabolism. Many patients are referred by physicians evaluating children for failure to thrive or for retardation. Some are discovered as the results of urine amino acid and organic acid screens performed in the Pediatric Metabolic Disease Laboratory at the College of Medicine. The greatest number of children followed by this service have phenylketonuria. Genetic counseling, psychological testing, nutritional and social services are available in the metabolic clinic. Phenylketonuria, galactosemia and maple syrup urine disease are part of the Statewide Neonatal Screening Program. The metabolic section provides confirmation of positive screening tests reported by the State Laboratory. Once the diagnosis is made, follow-up care is available through the metabolic disease section. Group educational programs are provided for the families with phenylketonuria and for galactosemia.

Regional Genetics Center

Serving southwest Florida since 1975, the University of South Florida College of Medicine Genetics Center provides clinical evaluation, counseling, and specialized metabolic and cytogenetic laboratory studies for the diagnosis and management of a variety of genetic diseases, which now number over 3,500.

In conjunction with the Perinatal Division of the Department of Obstetrics/Gynecology prenatal detection of chromosome abnormalities, neural tube defects,

and an increasing number of bio-chemical genetic disorders is available.

The College of Medicine is one of three major referral centers for the Florida Infant Screening Program providing confirmation of the diagnosis and clinical management for phenylketonuria, maple syrup urine disease, hypothyroidism, and galactosemia. The Center also offers carrier detection for Tay-Sachs disease, galactosemia, and several other enzymopathies.

Outreach clinics in St. Petersburg, Lakeland, Sarasota, and Ft. Myers offer genetic services for those who are unable to travel to Tampa, as well as educational opportunities for health professionals.

Pediatric Endocrinology Unit

Between September 1, 1973 and April 30, 1980, 1,567 patients were seen in the Pediatric Endocrinology Unit at All Children's Hospital. At present, outpatients are seen in the Pediatric Endocrine Unit three days per week.

The Department of Pediatrics Endocrinology Research Laboratory located at All Children's Hospital has been actively engaged in research efforts since inception of the section. Research efforts have concentrated primarily upon the hypothalamic-pituitary axis, mechanisms of puberty, and Vitamin D metabolism. This work has been funded by grants from the National Institutes of Health, the March of Dimes, and the Cystic Fibrosis Foundation. The fruits of this research effort have been published in more than 50 manuscripts.

Child Psychiatry Program

The Division of Child Psychiatry has attempted to fill specific community needs consistent with the College of Medicine training program. In cooperation with community agencies, three major programs have been developed:

- (1) A 12-bed inpatient unit for adolescents requiring residential psychiatric treatment for periods up to one year has been developed in cooperation with and housed in the Northside Community Mental Health Center in Tampa.
- (2) A 10-bed unit housed at the Hillsborough County Hospital manned in cooperation with the County Hospital and with Hillsborough Community Mental Health Center serves as a diagnostic center for severely disturbed children and adolescents. Definitive treatment and close cooperation with social support systems in the community are initiated here.
- (3) A child study and treatment center at the Medical Clinics provides comprehensive

neuropsychiatric, pediatric, psychological and educational evaluation for children of all ages. The faculty determines appropriate intervention and offers selected children specific treatment needed.

Burn Center

The Burn Center at the University of South Florida College of Medicine provides comprehensive medical care to the burn patient in all stages of his illness. The acute care is provided by the Department of Surgery Faculty and Residents at the Burn Unit of the Tampa General Hospital. The acute care is a multi-disciplinary approach to care for the burn patient including daily cooperation with other necessary disciplines. The Nursing Service, Dietetics, Occupational Therapy, Psychiatry, Physical Therapy, and Social Services are all involved in the care of the patient during the acute period. Rehabilitative and out-patient care is provided through the Burn Clinic at the University of South Florida Medical Clinics. Here the surgery faculty can provide all-encompassing rehabilitative care to the patient after his injury.

Head and Neck Cancer Contracts Program

The Division of Otolaryngology is conducting with the National Cancer Institute a prospective randomized trial entitled "Adjuvant Chemotherapy in Operable Head and Neck Squamous Carcinoma." Reliable data from trials in head and neck cancer utilizing chemotherapy in combination with other modalities has been limited in the past. This nationally based study will evaluate the efficacy of adjuvant chemotherapy containing cisplatin and bleomycin in the multidisciplinary treatment of advanced operable squamous cell carcinoma of the oral cavity and larynx. The trial has been underway since October, 1978. Thus far, 293 patients have been analyzed at USF in the ongoing three-year investigation. Results will be analyzed after a 2-3 year follow-up.

Hand Surgery Program

The Section of Hand Surgery within the Department of Surgery consists of clinical and fulltime academic faculty in the surgical specialties of orthopedic, plastic, general and neuro-surgery. Weekly hand clinics are scheduled at the University of South Florida Medical Clinics, Veterans Administration Hospital and Tampa General Hospital. Patients with upper extremity disorders secondary to trauma, arthritis, congenital malformations, and neurological disorders are attended to and followed by surgical and orthopedic residents who rotate through the service as part of their hand surgery or orthopedic surgery rotations.

A monthly conference is conducted which is well

attended by students, residents, and multispecialty surgeons from the Tampa Bay area and surrounding counties.

In September, 1980, the Microneurovascular Workshop was established at the Veterans Administration Hospital in order to teach and re-enforce microsurgical techniques. The facility is available to residents and attending surgeons in various surgical subspecialties, such as otolaryngology, neurosurgery, gynecology, urology, orthopedic, and general surgery. Incorporation of microvascular techniques within the training program has enabled the faculty to offer the community expertise in microvascular reconstructive procedures, such as replantation and free flap transfers. It is anticipated that the lab will serve as a focus for microvascular research in the future.

Trauma Service

The University of South Florida began an organized approach to care for a large volume of primary secondary, and tertiary trauma. The service was organized to provide instant, appropriate care for trauma victims who were brought to the Tampa General Hospital Emergency Room or transferred to the service from other institutions.

A chief resident plus one third year and two second year residents are assigned to this service. In addition to general surgical trauma, neurosurgical and thoracic trauma patients receive care. Patients with multi-system trauma are also cared for until their problem becomes confined to one system.

When patients present with injuries which necessitate surgical care, a member of the trauma team arrives to care for the patient. At least one member of the team is in the hospital 24 hours a day with a senior resident present as back up. A faculty member is immediately available for the various specialties involved. The attending physicians consist of a faculty supervisor assigned to the service plus all clinical and fulltime faculty members.

Presently, the emergency room is notified in advance of the impending arrival of a severely or critically injured patient. At such time, three to five surgeons will be awaiting the patient to initiate immediate resuscitation. They render care until the patient's attending surgeon arrives and continue if that patient is placed on

the trauma service.

Southeastern Oncology Group

The University of South Florida College of Medicine is a full member of the Southeastern Cancer Study Group. This cooperative group is a National Cancer Institute-funded association of over 20 cancer research institutions involving over 300 clinical oncologists throughout the country. More than 2,500 patients are registered annually on some 50 clinical trials developed by specialty committees composed of members from the individual institutions.

Numerous group-wide and pilot clinical studies are conducted at the University of South Florida. Ongoing studies cover a wide spectrum of hematologic and solid-tumor malignancies and include several surgical adjuvant studies and supportive care programs. The number of private oncologists interested in participation in such studies has been increasing rapidly. Enhanced communication with specialists and researchers at the other medical schools in the State and at cancer research institutions throughout the country has been a useful product of this association. The Group meetings which occur twice yearly and more frequent committee meetings, provide a fertile environment for the generation and discussion of clinical research ideas and evaluation of study results. Substantial progress in the understanding and treatment of malignant disease is being made through such cooperative clinical studies.

Summary

In summary, it is clear that despite the varying backgrounds and structures, the constant motivating factor in all these programs listed above is to provide specialized expertise by the College of Medicine faculty for the health care of the residents of Florida. The more usual but quite valuable functions of patient care provided by the University of South Florida Medical Clinics have not been listed in this presentation. The preceding programs, however, are of specialized nature and warrant individual attention not only because of their area of service, but also because none were in existence prior to the founding of the University of South Florida College of Medicine. Their emergence represents in a visible manner some of the valuable assets to the community provided by the presence of a modern College of Medicine.

Medical Library

The University of South Florida Medical Center Library was established in February, 1971 to serve the Colleges of Medicine and Nursing. Within the basic scope of materials are medicine and nursing subjects, with allied health fields covered as needed for teaching and research. Services offered are the usual ones for libraries, but they also include the computer literature search and the Selective Dissemination of Information services. Data bases used are those of the National Library of Medicine, Lockheed Missile and Space Company and the Systems Development Corporation.

Southeastern Library Program

The Library is a Resource Library as a part of the national Biomedical Communications Network and actively participates in this Network through the Southeastern Regional Medical Library Program (SERMLP). Health science libraries, physicians and health related personnel in 23 counties of Central Florida are served under this program, with the same assistance provided to faculty and students of the Medical Center.

The Central Office of the Tampa Bay Medical Library Network (TABAMLN) is headquartered in the library. The libraries of 15 community health providing institutions are members, representing Hillsborough and Pinellas Counties. At present, the Network is supported by grant funds obtained from the National Library of Medicine by the USF medical librarian. By January, 1982, local funding by the member institutions will be substituted for the federal money.

The medical library is designed to provide maximal functional support for the users, combined with pleasing aesthetics in its design and decor.

A total of 1,554 different medical journals are available; 56,545 volumes are housed in the library.

User-Oriented Library

The medical library is administered by a highly experienced and able medical librarian who has acquired and trained an excellent staff. The library is user-oriented and every effort is made to encourage and expand services to the approximately 1,000 medical center and

community users. The level of the various services rendered is high and continues to provide an important library resource for Central Florida. The library is part of the national Biomedical Communications Network of the National Library of Medicine. A comprehensive reference section is a heavily used part of the library facility.

A significant rare book and document section is being developed and will eventually provide a valuable research function. Approximately 250 seats are available in the library for study and research by students and faculty.

The medical library is an essential and highly valued centerpiece for the scholarly and investigational activities of the Medical Center.



Faculty Research

During the past decade the research programs within the College have developed into a major faculty endeavor.

The research grant budget for the 1980-81 academic year totaled \$3,140,430. This sum supports a large number of investigations in both clinical and basic medical science, conducted under the leadership of the department chairpersons. Listed below are a few of the research projects now active in each department, which represent an important part of the scholarly work being accomplished by the medical faculty.

Department of Anatomy

1. Anatomical and physiological organization of the somatosensory system.
2. Neuronal plasticity following damage.
3. Transcutaneous electrical nerve stimulation induced pain relief and analgesia.
4. Microcircuits of pain - the ultrastructural organization of the substantia gelatinosa.
5. Adenovirus induced cytopathology of interstitial pneumonia.
6. Neuroendocrinology: brain mechanisms that control the release of LH and prolactin.
7. Functional responses to hypothalamic damage including: neuroendocrine axis response, neurotransmitter responses and behavioral responses.

Department of Biochemistry

1. Ribonucleotide reductase of tumor cells.
2. A new approach to combination chemotherapy.
3. Cytotoxicity and ribosomal RNA maturation.
4. Tumor cell inhibition by nucleotide aldehyde analogs.
5. Regulation of cholesterol biosynthesis.
6. Regulation of glycoprotein synthesis.
7. Role of dolichylphosphate in glycoprotein biosynthesis.
8. Investigations into the regulation of glycoprotein biosynthesis in cystic fibrosis.
9. Role of platelet membrane glycoproteins in diabetes mellitus.

Department of Comprehensive Medicine

1. A comparative study of the ascarid succinate dehydrogenase/fumarate reductase system.
2. Schistosome susceptibility studies on Brazilian snails.
3. Concentration of human pathogens by commercially important shellfish, as affected by environmental factors.
4. *Biomphalaria straminea*: A potential schistosome vector in the Caribbean.
5. Immunomodulation of *Nippostrongyls brasiliensis*.
6. Development of an experimental model for *W. bancrofti* filariasis using nude mice.
7. A curriculum development designed to teach medical students occupational health.
8. Hospital-based occupational health nurses' predicative ability to assess appropriateness of employee/job placement.
9. Epidemiology of clinical cases of cholera infection resulting from ingestion of shellfish taken from polluted waters by non-pathogenic strains of *Vibrio Cholera*.

Department of Internal Medicine

1. Role of adrenal steroids in low renin hypertension.
2. The relationship between gas analysis, chemical and clotting profiles of pericardial fluid, and the etiology of pericardial effusion.
3. Effect of superoxide dismutase on the evolution of radiation induced pneumonitis.
4. Study of endotoxin on platelets.
5. Lithium carbonate attenuation of chemotherapy-induced neutropenia.
6. Paroxysmal nocturnal hemoglobinuria (PNH) and related disorders.
7. Endotoxin and complement mechanisms.
8. Platelet membrane glycoproteins in diabetes mellitus.
9. Control of aldosterone synthesis by angiotensin, KT and ACTH.

10. Adenosine release from cardiac muscle cells.
11. The efficacy of gallium-67 citrate in evaluating bile reflux gastritis.
12. Neutralization of prostacyclin (PGI₂) by heparin and effects upon platelets.

Department of Microbiology

1. Responsiveness of resident pulmonary alveolar macrophages of MHA hamsters to splenocytic mediators.
2. Pathogenesis of *Haemophilus influenzae* respiratory infections in BDF1 mice.
3. Proliferative response of mast cells in tracheal mucosa of hamsters exposed to the carcinogens, N - methyl - N - nitro sourea (LJP).
4. Natural cytotoxicity of mouse spleen cells to erythroleukemia cells treated with dimethylsulfoxide (DMSO).
5. Study of murine leukemia treatment in vivo and in vitro.
6. Immunity in Herpes simplex virus infection.
7. Detection of Herpes simplex virus by coagglutination using antisera complexed to protein A containing staphylococci.
8. Cardiotoxicity of Herpes simplex virus.

Department of Obstetrics/Gynecology

1. The effectiveness of cefoxitin compared to the placebo, in the prevention of infectious morbidity complicating radical abdominal hysterectomy.
2. Laser therapy in the management of cervical intraepithelial neoplasia.
3. Evaluation of premature rupture of membranes with conservative management.
4. Fenoterol versus ritodrine-randomized double blind study.
5. The use of prostaglandins for induction and intrauterine fetal death greater than 28 weeks of gestational age.
6. Incidence of endometriosis found at laparoscopy in fertile and infertile women.
7. Voice pattern changes in women using oral contraceptives.
8. Compositional changes of amniotic fluid surfactant.
9. Cefamandole and tobramycin in the treatment of non-gonococcal salpingitis.

Department of Ophthalmology

1. Role of anerobic organisms in the etiology of infectious keratitis.

2. Electrophysiological measures of diabetic retinopathy.
3. Localization of the sources of the human visual evoked cortical responses.
4. Clinical utility of the macular electroretinogram.
5. Testing of the EEG-eye movement artifact hypothesis.
6. Twin study of macular degeneration.
7. Retinal findings in CREST syndrome.
8. Electrophysiology of diabetic retinopathy.

Department of Pathology

1. The surfactant system in adult respiratory distress syndrome.
2. Human tumor xenografts in immunodeficient mice.
3. The surfactant system in diffuse alveolar damage.
4. Compositional changes of amniotic fluid surfactant.
5. Studies on histone methylation in erythroid cell nuclei.
6. Stabilization and maintenance of PGI₂ (prostacyclin) activity in subcultured endothelial cells.

Department of Pediatrics

1. Comparison of the distribution of lipids in breast fed compared to bottle fed infants.
2. The effect of acidosis on hypoglycemia.
3. Evaluation ofsecondarymetabolic alterations in human Gal-1-P uridyltransferase deficient cell cultures.
4. Characterization of several unique chromosome aberrations.
5. MHPG quantitation in failure to thrive of non-organic origin.
6. The influence of diabetes upon vascular endothelial cell growth.
7. Carnitine and 20% intralipid in very low birth weight newborns.
8. The effect of trace metals on hypothalamic pituitary function.
9. Regulation of vitamin D metabolism: Effect of pituitary hormones.

Department of Pharmacology/Therapeutics

1. The neurochemistry of addiction.
2. Calcium and phosphoinositides in vascular function.
3. Histamine tachyphylaxis in airway smooth muscle.
4. Glucocorticoid receptors and cleft palate in mice.
5. Drugs and excitation - contraction coupling in the heart.
6. Opiate receptors in the retina.

Department of Physiology

1. Influence of respiratory muscle mechanoreceptors on the central control of breathing.
2. Respiratory rhythm generation: neural mechanisms.
3. The role of cerebral spinal fluid pressure in the control of vasopressin.
4. The effects of cardiovascular and osmotic receptors on the activity of vasopressin neurons and plasma levels of the hormone.
5. Calcium fluxes in vascular smooth muscle during E-C coupling.
6. Physiological properties of arteries in hypertension.
7. Microvascular flow, volume, and reactivity.
8. Cutaneous microvascular and macrovascular responses.
9. Capillary flow patterns in hypertension.

Department of Psychiatry

1. Psychosocial factors in high-risk pregnancy.
2. MHPG levels in anorexia nervosa.
3. Pain control strategies in the burn unit.
4. Quality of inpatient psychiatric care given to Baker Act eligible persons (indigent patients) in the Hillsborough-Manatee District.
5. Clinical study of the effectiveness of family therapy.
6. Patterns of use of inpatient psychiatric services among veterans treated at the Tampa VA Hospital.
7. A study of the effectiveness of the family protection team.

Department of Radiology

1. Pitfalls of posterior fossa aneurysm diagnosis.
2. The changing radiographic workup of subarachnoid hemorrhage.
3. Unusual clinical presentations of juvenile lumbosacral spine discitis.
4. Brainstem anatomy as seen on cranial CT.
5. Frequency of observation of empty sella in asymptomatic patients with cranial CT.
6. Intradural sacral lipoma and tethered cord: Definitive diagnosis by computed tomography.
7. Spontaneous thrombosis of carotid cavernous aneurysms.
8. Brainstem telangiectasia.

Department of Surgery

1. Adjuvant chemotherapy in operable head and neck squamous carcinoma.
2. Thoracic and cardiovascular: Edema prevention during ischemic cardioplegia.
3. Magnetically-actuated left ventricular assist device.
4. Bio-engineering in the treatment of urinary incontinence and impotence.
5. Treatment of carcinoma of the prostate.
6. Research plan for early detection of prostatic cancer.
7. Edema prevention during ischemic cardioplegia.
8. Intestinal oxalate absorption in malabsorption syndromes.
9. Immunologic functions of the spleen.

Continuing Medical Education

At the University of South Florida College of Medicine continuing medical education is considered to be an integral part of an overall educational commitment to the State and community. Our goal has been, and continues to be, to provide ready accessibility to high quality CME programs for all physicians, with particular emphasis on the needs and desires of the physician in practice. This program complements, extends, and modifies the educational process begun in medical school and continues in varying degrees during postgraduate training. CME is an integral part of the educational continuum in our institution.

In 1975, the College of Medicine was accredited by the American Medical Association (AMA) as a provider of Category I credit for CME programs. With this accreditation status, the programs presented or co-sponsored by the College of Medicine were recognized as meeting the standards for CME programs as defined by the AMA. Consequent to this recognition, the Florida Medical Association has also accepted our Category I programs as fulfilling their requirements for its Mandatory Credit. Selected appropriately planned courses by the College have also been approved for Prescribed Credit by the Florida Academy of Family Practice. It therefore is obvious that accreditation of the USF program has had great impact on the CME activities in this area.

The Accreditation Process

The accreditation process for CME over the past three and a half years has undergone a series of changes. Initially our approval was granted by the AMA after a review of our application and a subsequent site visit by a three-member survey team in February of 1975. In 1977, the AMA plus the AAMC and five other national groups merged to form the Liaison Committee on CME (LCCME). Following another application and a review by the LCCME we were accredited by the LCCME. We were then approved by the two national committees of the AMA and of the LCCME.

In July, 1979, the AMA withdrew from the LCCME and re-established its own approval process again. This dual status for approval continued until January 1, 1981, when, under a revised set of guidelines, the AMA and the LCCME again merged under the name of the Accredita-

tion Committee for CME (ACCME). In the coming year, our CME program must be re-evaluated and approved by the ACCME.

The initial educational goals of the College of Medicine during its early development were concerned primarily with the educational program for medical students and in implementing residency programs. Because of "the newness" of the College of Medicine and the small number of initial faculty, the approach to Continuing Medical Education was, of necessity, small in volume. This approach avoided an initial over-commitment of funds, faculty, and staff, but once established and accredited, the continuing education program grew rapidly.

Coordination of Activities

Initially, the Assistant Dean for Curriculum and Postgraduate Education assumed the responsibility for the record maintenance and primary coordination of activities of the CME programs. This function subsequently became the responsibility of the Associate Dean for Continuing Medical Education. Throughout this evolution, it was envisioned that the CME program would be more centralized and coordinated. There would be additional support, preparation, and evaluation of the CME programs through further development of the office of CME.

Even from the beginning, the College developed some programs of excellence in continuing education. These sessions were attended by physicians and medical educators from across the nation.

AMA Regional Meeting

In February 1975, the College agreed to sponsor the first regional American Medical Association Postgraduate Continuing Medical Education Meeting. The Department of Internal Medicine arranged the program and its faculty provided many of the featured speakers. The meeting was a substantial success and led the way for regional seminars which have been presented by the AMA each year thereafter. It was an honor and a stimulating experience for a new college of medicine to be afforded such an excellent opportunity for exposure at the national level. The Department of Internal Medicine

and its faculty certainly made the most of this opportunity with much positive and favorable notice being reflected upon the College.

Another offering in continuing education presented at the National level is the Mid-winter Seminar in Obstetrics and Gynecology, produced by the American College of Obstetricians and Gynecologists in cooperation with the USF College of Medicine. This meeting is always oversubscribed and for several years has afforded the faculty of the USF Department of Ob/Gyn an excellent opportunity to display the talents and abilities of its members to a nationally based audience of practicing obstetricians and gynecologists. The success of these meetings has embellished the reputation of the department and the College.

Nutrition Symposia

In 1973, the Department of Pediatrics began the first of a series of Symposia on Nutrition. Nationally recognized authorities on the subject presented elegant and sophisticated material in this important area. As in the previously described excursions in continuing medical education, the members of the Department of Pediatrics provided purposeful and favorable exposure for the College and their department.

A fourth impressive and important national exposure for the College was the origination of the Suncoast Trauma Symposium. In 1974, the Department of Surgery instituted a nationally advertised continuing medical education seminar on trauma. The format provided for three and one-half days of lectures and demonstrations concerning life saving measures for the critically injured. Four nationally prominent visiting professors joined physicians from the community and from the Department of Surgery to present the program. The Annual Suncoast Trauma Seminar continued to be well received by physicians and in 1977, completion of the auditorium at the College of Medicine provided a superb facility for conducting the seminar.

As of 1980, more than 1,000 physicians from 40 states and four foreign countries have attended the course. The distinguished visiting faculty who have been largely responsible for the success of the Annual Suncoast Trauma Seminar has included many outstanding surgeons from major universities in the United States. These physicians, as well as their audience, have responded enthusiastically to this continuing medical education course.

Cancer Program

The Cancer program produced annually by the Department of Radiology is another example of a highly regarded CME offering. A Cancer Seminar has been held under the sponsorship of the University of South Florida College of Medicine since 1976.

The procedure of Cancer Seminar was originated by Dr. J.A. del Regato, formerly director of the Penrose Cancer Hospital of Colorado Springs, where these events took place annually for 25 years. For the past six years, a new series of Cancer Seminars has been sponsored at the University of South Florida. Dr. del Regato is professor of Radiology at USF and distinguished physician for the VA at Tampa.

The Cancer Seminar is a special educational and research exercise, a basic confrontation of the patient's history and symptoms with the x-ray appearance and the microscopic tissue diagnosis; the known evolution of the case helps further in reaffirming or contradicting the original diagnostic impression.

Fifteen problem cases are presented in succession. The expert opinion of the guest radiologist is presented, followed by that of the guest pathologist. The opinions of a number of national and foreign experts are introduced into the proceedings. The discussion is opened by a guest speaker. An opportunity is open to all present to participate in the discussion. Edited proceedings of the Cancer Seminar are published.

Recurring Local Conferences

Regularly recurring locally based conferences were sponsored by the various departments early in the history of the College of Medicine. These weekly or monthly conferences have continued to the present. At many of these conferences, seminars, rounds, workshops, and lectures, distinguished guest speakers are featured as well as members of our own faculty. Practicing physicians are also cordially invited to attend these sessions as a part of their life-long learning activities.

In 1975, seven formal CME courses were sponsored or co-sponsored by the College of Medicine. The number increased to fifteen in 1975, twenty-seven in 1976, and forty in 1979-1980. There has been a concomitant increase in the number of registrants attending these programs. Additionally, the faculty of the College of Medicine has been actively involved in a CME outreach program. These programs include participation in conferences at community hospitals, society meetings, and meetings of various specialty groups. The outreach programs have been very successful and have provided a forum and a format for an interchange of ideas, a sharing of mutual concerns and a better understanding of the goals and needs of both the practicing community and the fulltime faculty. Future CME activities in this area may include "mini-residencies", expanded bio-medical electronic communications, the use of computers and a teleconference network.

Faculty Participation

Faculty participation in the planning for the content

of CME programs since their inception has been accomplished at the departmental level. At department meetings, faculty members provide information concerning areas of need in clinical practice, ways of accomplishing effective programs to meet these needs, as well as plans for addressing presentations of newer information.

Additionally, program content and development are discussed using information obtained from the registrants and other physicians by informal discussions and through evaluation questionnaires. Future goals will be to develop better and more effective ways of evaluation of both individual programs and of CME as a whole.



What of the Future?

The future of this young college will inevitably involve many elements of maturation common to most such institutions during the second decade of their existence. The first 10 years have been relatively smooth despite a few crises which are inevitable in a new and developing enterprise. But a variety of problems will without doubt result in a less serene course in the years to come.

A number of important determinants may indeed become inevitable and will probably significantly impact upon our future development. These factors are relatively new, having become visible only during our first 10 years. Chief among these will be ever increasing strains upon our financial resources.

Too Many Doctors?

In dramatic contrast to the oft repeated demand for "more doctors" of but a few years ago, we now hear, with increasing frequency, the question, "Do we have too many doctors"? Once established, medical schools rarely close their doors, but in many situations financial support is based upon enrollment figures. Mandated reduction in class size might thus seriously endanger continuation of adequate monetary allocations. Legislators and governing agencies often fail to appreciate the fact that basic educational needs are only minimally reduced by reductions in enrollment. This is particularly true in the case of medical education.

Diminished financial support at all levels is already making its appearance. Reduced federal funding of research, an important obligation of medical colleges, is already having its effect upon faculty recruitment. "Capitation" support by the federal government for educational costs will soon become a thing of the past. Limited state budgetary resources will be strained to the utmost. One inevitable consequence, also already becoming apparent will be increasing dependence upon faculty practice income, here as elsewhere, as an alternative major source of support.

Cancer Care and Research Center

A new assured and important step forward into the

future of the College will be the construction of a 63 million dollar Cancer Care and Research hospital. This highly specialized facility will provide frontier of medicine type of care and research in oncology.

In coordination with patient care, medical student, housestaff, nursing and technician education will be conducted. The overall expansion of the College of Medicine into the practice of this particular type of inpatient medicine will represent another important event in the development of this vibrant and growing center of medical education.

The Teaching Hospital

Fortunately, our physical plant lacks but one element for completion of the plan originally approved and adopted by all elements of local, state and federal government: Phase III of our construction master plan, the Teaching Hospital.

Seventy years ago, in his famous report which revolutionized medical education, Abraham Flexner pointed out that it is no more logical to expect to teach medicine in a borrowed facility than to ask a physics professor to teach in a borrowed laboratory. And the Dietrich-Berson Survey of Medical Schools in the United States at mid-century pointed out that "A hospital not under direct University control can rarely if ever provide ideal conditions for education since it rarely exists for this purpose."

Fortunately, these considerations were well recognized by our founders who included a teaching hospital in all basic plans, recognizing that the ideal educational pattern for clinical instruction must indeed be a teaching hospital, always supplemented by additional student experience in community institutions whose major concern is, and should be, patient care. Need will surely dictate that, sooner or later, construction of a teaching hospital will fulfill the original plan and bring about completion of a truly complete constellation of facilities for patient care, teaching and research.

Hopes and Visions

Our hopes and visions of the next ten years include a considerable and continuing increase in the stature and

national recognition of the College as an outstanding member of the community of Medical Colleges. It is hoped that our graduates of both the past and future will, by outstanding performance, reflect luster and approbation upon The College. We look forward to an increasingly mature and productive faculty, joined by the requisite number of newly trained able young medical educators.

Fortunately, medical schools are durable institutions. Through the years they have survived despite numerous and varied crises nearly always emerging stronger and more effective.

All in all, recognizing the complicated and serious nature of the new problems which will arise, the future of the College is assured. Problems which are recognized and analyzed are always subject to successful solutions.

The future of the USF College of Medicine will surely see the accomplishment of continuing excellence in teaching, research and patient care. This bright future will be made possible by the efforts of an able and dedicated faculty, effective leadership within the administration, and by the presence of highly motivated students and house staff.



This is our future . . . the Class of 1984



PROFESSIONALLY CHALLENGING ...
PERSONALLY REWARDING ...

FLORIDA

SPECTRUM EMERGENCY CARE, dedicated to quality health care, is the leader in the management and staffing of over 220 emergency facilities in 33 states.

SPECTRUM currently offers opportunities throughout the STATE OF FLORIDA to qualified physicians who are seeking:

- * A guaranteed annual income - Production based bonus system.
- * Paid Professional Liability Insurance.
- * Flexible scheduling with regular hours; no on-call involvement.
- * Director and clinical positions; full and part-time opportunities.
- * Metropolitan and rural settings ... high and moderate annual patient visits.
- * Continuing medical education reimbursement; assistance with licensure expense.
- * Career growth potential.
- * Association with medical management experts in the emergency health care field.

Physician interviews are currently in progress. Inquiries are invited by contacting Mr. John Kutchback toll-free at 1-800-325-3982 or by forwarding credentials in complete confidence to Spectrum Emergency Care, Inc., 970 Executive Parkway, St. Louis, MO 63141.

MICROSURGERY COURSES

The Microsurgery Laboratory at the University of Florida offers three and five day courses aimed at teaching techniques applicable to:

Extracranial to Intracranial Bypass
Digital Reimplantation
Tubal Reanastomosis
Vasovasostomy
Transsphenoidal Surgery
Temporal Bone Dissection
Other Microsurgical Operations

For Information write:

Mrs. Cindy Brady
Microsurgery Laboratory
Box J265
University of Florida Health Center
Gainesville, FL 32610

Just tell us where you want to live.

Hospital Corporation of America assists hundreds of physicians in locating solid practice opportunities each year. With HCA, you can choose a community that fits your lifestyle and know that the local hospital's staff and facilities will reflect your own high professional standards.

HCA owns or manages over 150 hospitals from San Francisco to Virginia... from Boston to Miami. Each hospital is well equipped, and professionally accredited and staffed. Practice opportunities are available in solo, groups, associations and

partnerships.

Contact HCA today. Let our free, no obligation Professional Relations Program match your needs with an HCA practice opportunity. Just send your curriculum vitae, with information on your personal, professional, and geographic interests to: **Charles M. Wooden, Director, Professional Relations, Hospital Corporation of America, One Park Plaza, Nashville, TN 37203. Telephone toll free 1-800-251-2561 or call collect (615) 327-9551.**

HCA Hospital Corporation of America

UNIVERSITY OF MIAMI
SCHOOL OF MEDICINE

TUTORIAL COURSES OF
INSTRUCTION IN
CORONARY CARE

Director: Louis Lemberg, M.D.
Co-Directors: Kyriacos Pefkaros, M.D.
Robert J. Myerburg, M.D.

SCHEDULE OF COURSES

1981	1982
August 3-8	January 18-23
September 14-19	February 15-20
October 26-31	March 8-13
December 7-12	March 29-April 3
	June 14-19

(For more information please call (305) 325-6411 or complete coupon and mail to: M. Enriquez, Division of Cardiology (D-39), University of Miami School of Medicine, Post Office Box 016960, Miami, Florida 33101).

Please send me more information regarding
Tutorial Courses of Instruction in Coronary Care

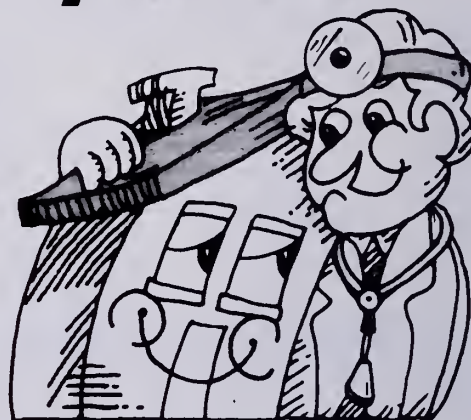
Name _____

Phone () _____

Address _____

_____ Zip _____

**When you need
a lot of money,
DAC and your
house may be
the best friends
you have.**



As a physician, cash flow and large dollar requirements can sometimes be a problem. Probably one of your biggest assets and surest means of obtaining large cash sums is your home equity.

Let DAC show you how simple it can be to arrange a home equity loan. Loans are available for up to \$50,000 or more with terms up to 12 years.

So, if you need cash for setting up or expanding a practice, new equipment, business investments, major purchases, etc., call your nearest DAC office — there are 13 in Florida!

Licensed Mortgage Broker

DAC
Corp. of Fla.

An affiliate of The Old Stone Bank

Professionals Helping Professionals For Over 20 Years

Bradenton
6221 14th St. West
756-9575

Clearwater
2280 U.S. Highway 19 N
796-2587

Daytona Beach
2040 S. Ridgewood Ave.
761-8500

Ft. Lauderdale
1771 N. W. 40th Ave.
735-5111

Jacksonville
3986 Boulevard Center Dr.
396-9496

Lakeland
402 S. Kentucky Ave.
687-2533

Melbourne
17 E. Hibiscus Blvd.
727-3510

Ocala
2945 N. E. 3rd St.
732-4336

West Palm Beach 2240 Palm Beach Lakes Rd 689-0080

Orlando
3438 Lawton Rd.
894-3711

Pensacola
5150 Bayou Blvd
478-3215

Tallahassee
2574 Seagate Dr
878-3149

Tampa
402 Reo St.
879-3181



Correspondence

BOARD OF NURSING QUESTIONS PHYSICIAN EXTENDER ARTICLE

To the Editor: As chairman of the Florida Board of Nursing, I feel compelled to correct several serious inaccuracies re: ARNP's in the article entitled "Physician Extenders in Florida," by Dr. Richard J. Feinstein, M.D., which appeared in your May, 1981, issue on page 371.

First, the article states that the Board of Nursing has not passed any rules requiring an ARNP to operate under written protocol. This is untrue. The nurse practice act requires the ARNP to function only pursuant to an "established" protocol and the Board by rule has defined the term "established" protocol to mean that it must be written.

Second, the article accuses the Board of Nursing of "choosing not to enforce" the statutory requirements for supervision of the ARNP by a physician or dentist because the Board does not require the nurse to file protocols, which include the name of the physician supervisor with the Board or the Department of Professional Regulation. In fact, the Board chose not to require the filing of volumes of paper and forms with a governmental agency because it is unnecessary and will not assist the Board or Department in any way to enforce the law. By statute, department investigators have legal access to the written protocol and records of any ARNP, and the Board of Nursing stands on its own record of vigorous enforcement of the nurse practice act, with regard to RN's, LPN's and ARNP's.

Third, the article notes that an ARNP may perform, "along with nursing acts" additional medical acts of diagnosis, prescription, treatment and operation as approved by the joint committee composed of members of the Board of Nursing, Board of Medical Examiners and the Secretary of Department of Professional Regulation. The author goes on to accuse the Board of Nursing of allowing performance of these medical acts through its own rules without the approval of the joint committee. This is a gross misrepresentation of fact. The author failed to note that in addition to nursing acts and com-

mittee-approved medical acts, the statute itself specifies certain *additional* acts that each category of ARNP may perform. I emphasize that the legislature itself authorizes performance of these acts; not the Board of Nursing, not the Board of Medical Examiners and not the joint committee. Where clarity or implementation of the law is required, the Board has adopted the appropriate rules, but in no event has the Board allowed performance of any medical act not specifically authorized by law nor has it ever attempted to usurp the functions of the joint committee.

With regard to preparation for advanced practice, ARNP's must first complete a program of at least 2½ to 3 years, which prepares RN's, and pass the national professional nurse licensing examination. After working in the health care field, the ARNP must complete a specialty program of *at least* one academic year which meets the criteria established by rule of the Board of Nursing. National specialty certification exams are available to ARNP's through such professional associations as ACNM, AANA, NAACOG, NAPNAP, and ANA.

ARNP's are professional nurses accountable and responsible for their actions and decisions and are subject to disciplinary action by the Board of Nursing. If Dr. Feinstein is aware of "certain groups of ARNP's", who are practicing medical acts outside the scope of their authority or who are not acting in accordance with an established protocol under proper supervision of a physician or dentist, I strongly urge him to report his knowledge to the Department of Professional Regulation, so that an investigation may be conducted, and if in fact a violation has occurred, the Board of Nursing may impose the proper discipline.

I hope this letter serves to set the record straight on an issue I feel is of great importance to both the medical and nursing professions.

(Mrs.) Mern Henry, R.N.
Chairman
Florida Board of Nursing

NURSE ANESTHETISTS AS PHYSICIAN EXTENDERS

To the Editor: The May 1981 edition of *The Journal of the Florida Medical Association* contained a special article, "Physician Extenders in Florida," by Dr. Richard J. Feinstein. I was particularly interested in the section having to do with nurse anesthetists and, specifically, the educational program for them at the Shands Teaching Hospital and Clinics, Inc., in Gainesville. Dr. Feinstein intimated that the educational program for nurse anesthetists at the Shands Hospital was one academic year in length and, further, that entrance into the program is available to nurses with an associate of arts degree, a three-year hospital nursing school diploma or a baccalaureate degree. Finally, he stated that supervision by a physician or dentist is not required by the Nurse Practice Act and, therefore, the advanced nurse practitioner, essentially, can practice medicine without supervision.

The program in nurse anesthesia at Shands Teaching Hospital considers no one eligible for entrance into the program unless the applicant has obtained at least a bachelor of science degree in nursing or in an allied science in addition to having completed the requirements to be licensed as a nurse. Also, in addition to the BS, we require that our applicants have at least one year's experience in an area of critical care nursing. We select two or three students per year from an applicant pool of approximately 200. Once accepted into our program, these students must successfully and entirely complete 24 months of training; it is not possible for them to graduate in less time.

Passed by the 1979 Legislature, the Nurse Practice Act clearly states, "Unless otherwise specified by the joint committee, such acts [advanced or specialized nursing practice] shall be performed under the general supervision of a practitioner licensed under chapters 458, 459 or 466 within the framework of standing protocols which identify the medical acts to be performed and the conditions of their performance." Further, the sections specifically addressing the nurse anesthetist state, "The nurse anesthetist may, to the extent *authorized by established protocol approved by the medical staff of a facility in which the anesthetic service is performed*, perform, in addition to the general functions in subsection (3), any or all of the following . . ." (emphasis added). The act then goes on to state nine areas in which the nurse anesthetist can perform *only* under the general supervision of a licensed practitioner and after approval of the protocol by the medical staff of the facility. Furthermore, unlike many other physician extenders, there is a national certifying examination for nurse anesthetists. Many hospitals require passage of this examination prior to granting employment.

Thus, while the interpretation of the law regarding physician extenders may be loose in some areas, I believe that it is quite specific for the nurse anesthetist in that the medical staff of the hospital and also the physician supervisor determine what can appropriately be performed under supervision. Further, I believe it is important that the readers of *The Journal of the Florida Medical Association* realize that the program in nurse anesthesia at Shands Teaching Hospital in Gainesville has rigorous requirements for both admission to and completion of training.

Jerome H. Modell, M.D.
Professor and Chairperson
Department of Anesthesiology
University of Florida
Gainesville

REBUTTAL FROM THE AUTHOR

To the Editor: The requirement for the use of protocols by nurse practitioners was written into the statutes by the Florida Legislature. Chapter 464.012(3) refers to protocols for all functions of nursing specialists that are described in the statute, and 464.003(3)(c) describes the requirement for protocols for any additional functions that are granted to nurses by the joint committee. The lack of Nursing Board rules concerning protocols that I alluded to, were rules which would require the Nursing Board to inspect each and every protocol to ensure that they are credible and reasonable. The Board of Medical Examiners inspects the application and protocol of every candidate for certification as a physician's assistant. The Medical Board must deal with the mountains of paper work that Mrs. Henry fears, but we believe that the inspection of each protocol prior to certification is in the best interests of both the public and the health profession.

As a member of the joint committee, I spent countless hours involved in discussions of additional functions that were requested by nursing specialists. We also discussed new categories of nurse practitioners, who sought recognition, but who were not mentioned by the Legislature in the statutes. After a year of such meetings, the Nursing Board and their attorney concluded that the joint committee had no jurisdiction over such requests, and they implemented the additional functions through their own rules. These additional functions, such as the insertion and removal of IUDs and diaphragms, and the dispensing of oral contraceptives, were functions granted to nurse practitioners by the Board of Nursing, though they were not mentioned in the statutes, and they were not approved by the joint committee.

Mrs. Henry's last point about length of education, can be answered along with Dr. Modell's letter. The law allows a registered nurse, who may have graduated from a two year junior college, to then receive one academic year (ten months) of post-basic education, to be eligible for certification as a nurse practitioner by the Board of Nursing. Such certification grants the nurse a great deal of additional responsibilities in patient care situations, and my article questioned whether the requirements should be made more stringent. Another solution would be to grant varying levels of responsibility, so that a nurse with both a bachelors and masters degree in a nursing specialty, could be given greater legal responsibility than the nurse practitioner who received only the minimum amount of education. Dr. Modell's educational program for nurse anesthetists is an example of an excellent educational program which is more demanding than the law requires. There are other such excellent programs, such as the Nurse Midwife program in Miami. These two categories of nurse practitioners also have national certifying examinations for their specialty, though the state does not require them.

My article should not be interpreted in any way as a general assault on the nursing profession or on nurse practitioners. They are invaluable health professionals who are of great benefit to patients and to the health care

industry. As a member of the State Board of Medical Examiners, I have seen examples of physicians who are incompetent and fraudulent, and I fear that there may be some deceitful nurse practitioners who would manipulate the weaknesses in the statutes for their own benefit. All laws must be directed at the lowest members of the profession. I believe that the Nursing Board should worry less about paper work and more about ensuring competent care to patients, and the survival of the nurse specialist. This can be accomplished by their being overly cautious and restrictive during these early years of the advanced nursing specialist in Florida. Educational programs which are stricter and more rigorous than the law requires, such as Dr. Modell's program in Gainesville, will ultimately benefit the nursing profession as well as the patients. The statutory requirement for medical supervision serves not only as a method to guarantee the continuing dialogue and educational interaction which will benefit nurse and physician alike. I believe that the Nursing Board should require individual medical practitioners to be responsible teachers and supervisors for the nurse practitioners whom they work with.

*Richard J. Feinstein, M.D.
Miami*

Registration Still Being Accepted For Intervention Workshop

FMA members wishing to attend the Workshop on Intervention with Impaired Physicians in Tampa this month still have time to register.

The two-day program will be held at the new Tampa Marriott Hotel from 8:00 a.m. to 5:00 p.m. on Friday and Saturday, September 25-26.

Upon completion of the program, physicians will be able to function as intervenors on behalf of the Commit-

tee with physicians believed to be impaired because of alcoholism or drug addiction.

Physicians interested in attending the program should contact: Dolores A. Morgan, M.D., Medical Director, FMA/FMF Impaired Physicians Program, 7400 S.W. 62nd Avenue, Miami, Florida 33143, Telephone: (305) 661-4611.

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal*.

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Abstract. All scientific manuscripts should include a 150 word, maximum length, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given:

names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request".

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double-spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication".

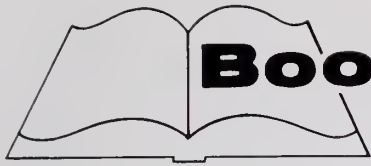
When received, the senior author will be sent an acknowledgement of receipt and a copyright agreement which must be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

Medical
Decorators

NEW OR EXISTING SPACE
PROFESSIONALS WORKING
AROUND YOUR SCHEDULE

(305) 772-0090
By Appointment

CARY MARTIN
5055 N.E. 13 Ave.
Fort Lauderdale, Fla. 33334



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Current Surgical Diagnosis and Treatment, Fifth Edition edited by J. Englebert Dunphy, M.D., and Lawrence W. Way, M.D. 1,138 Pages. Price \$25.00. Lange Medical Publications 1981.

The fifth edition of this surgical text has available translations in Spanish, Japanese, Portuguese, and Serbo-Croatian. Anticipated additional translations will be in German, Italian, Polish, French, and Turkish. In addition to Drs. Dunphy and Way are the contributions of 78 associate authors.

If all physicians emulated the doctor-patient relationship as expressed by Dr. Dunphy, an outstanding level of care and concern for the patient would become a world standard.

The text attempts and succeeds in providing basic information in concise form of multiple surgical specialties. An excellent resource therefore for the medical student, resident, and practicing physician. My suggestions for the sixth edition would be a precise presentation of critical care medicine with basic coverages of pulmonary physiology and practical ventilator management. I congratulate the authors on the compilation and updating of a fine surgical text.

Norman M. Kenyon, M.D.

Dr. Kenyon is an Assistant Editor of *The Journal*, and is engaged in the practice of surgery in Miami.

Liver Biopsy Interpretation, Third Edition, by Peter J. Scheuer, M.D. 260 Pages. Price \$65.00. Macmillan Co. Riverside, New Jersey, 1980.

Dr. Scheuer certainly intends to keep those involved in interpreting liver biopsies well informed. This third

edition, while basically not differing significantly from the second edition, is still a well presented contribution to this difficult subject. The text has been revised and the most recent advances in the histopathology of the liver updated. The illustrations have been rearranged to better advantage of the reader and the references brought up to date. Overall, this book will be a worthwhile edition for those interested in the field of liver biopsies, especially for those who are not in possession of the second edition.

Albert V. Drlicka, M.D.

Dr. Drlicka is in the private practice of pathology in Pensacola.

An Easier Way: Handbook for the Elderly and Handicapped, by Jean Vieth Sargent. 220 Pages. Illustrated. Price \$10.50. Iowa State University Press, Ames, Iowa, 1981.

This spiral-bound volume is nothing more than a catalogue of manufactured devices designed to make life less cumbersome for the physically disabled. Here is a brief description of an automated needle threader, an eyeglass holder, a rolling stand for a scrub bucket, and long-handled tongs of various sizes and designs. The author has referenced each item as to where it can be purchased.

Some of the items are ingenious, while others appear to be gimmicks of dubious value. The descriptions are concise, but in many cases, the author has sacrificed clarity for brevity. This flaw is particularly noticeable in the descriptions of items to be made at home. Disappointing is the fact that a perusal of the average mail order catalogue will yield essentially the same suggestions.

S.L.M.

Alert and
functioning
in the
sunset
years

Treat the symptoms in
the geriatric patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule contains:

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

OCTOBER

X-Ray Interpretation for the Primary Care and Emergency Physician, Oct. 1-4, St. Petersburg. For information: Sharon G. Llera, Administrative Assistant, Professional Services, Emergency Medical Services Assistants, 1400 66 Street, Suite 260, St. Petersburg 33710.

Parenting and Reparenting, Oct. 2, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Fort Walton Beach 32548.

Management of the Patient in Respiratory Distress, Oct. 4-5, Sheraton at St. Johns Place, Jacksonville. For information: Marge Lassiat, R.N., C.E.N., Administrator-EMCES, Inc., P.O. Box 5178, Jacksonville 32207.

Recent Advances in Gastroenterology, Oct. 6, Jess Parrish Memorial Hospital, Titusville. For information: Richard Barr, M.D., Jess Parrish Memorial Hospital, Titusville 32780.

Evaluation and Therapy of Shock and Drowning, Oct. 15, Ft. Myers. For information: Irwin J. Kash, M.D., Chairman, Department of Pediatrics, 3949 Evans Avenue, Suite 207, Ft. Myers 33901.

22nd Annual Workshop in Electrocardiography, Oct. 15-19, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, 601 12th Street, North, St. Petersburg 33705.

Current Concepts in Cardiac Rehabilitation, Oct. 21-23, Hilton Inn Florida Center, Orlando. For information: Zeb C. Bruton, M.D., 1230 East Hillcrest, Orlando 32803.

Occupational Health Managers on the Company Team, Oct. 23-24, Hilton Hotel, Jacksonville. For information: Mary Green, R.N., COHN, Southern Bell Employee Health Service, Jacobs Building, P.O. Box 390, Jacksonville 32201.

Applications of Psychiatry to Family Practice, Oct. 24, University of Florida, JHM Health Center, Gainesville. For information: Office of CME, University of Florida College of Medicine, Box J-233, JHM Health Center, Gainesville 32610.

Annual Postgraduate Course (Gastroenterology), Oct. 29-31, Sheraton Bal Harbour, Bal Harbour. For information: Daniel Weiss, Executive Director, 299 Broadway, New York, New York 10007.

Clinical Chemistry Review, Oct. 30, Florida Junior College of Jacksonville, North Campus. For information: American Society of Clinical Pathologists, 2100 West Harrison Street, Chicago, Ill. 60612.

NOVEMBER

Clinical and Electrophysiological Appraisal of Signs of Radicular Injuries in Back Pain, Nov. 2, Jess Parrish Memorial Hospital, Titusville. For information: Richard Barr, M.D., JPMH, Titusville 32780.

Selected Topics in Cardiology, Nov. 4-6, Wolfson Auditorium, Miami Beach. For information: Philip Samet, M.D., 4300 Alton Road, Miami Beach 33140.

5th Annual Medical Aspects of Aging, Nov. 5-7, Gainesville Hilton, Gainesville. For information: Office of CME, University of Florida.

Clinical Management of Coronary Disease and Exercise Testing, Nov. 6-8, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood, CO 80112.

Southeastern Section, Postgraduate Seminar, Nov. 6-8, Sheraton Bal Harbour Hotel, Bal Harbour. For information: Victor A. Politano, M.D., Southeastern Section, Postgraduate Seminar, 6614 Miami Lakes Drive, East, Miami Lakes 33014.

Management of the Arthritides: 1981, Nov. 12-14, Ponce de Leon Motor Hotel, St. Augustine. For information: Louis M. Sales, M.D., 1204 LeBaron Avenue, Jacksonville 32207.

14th Family Practice Review, Nov. 16-20, Hotel Royal Plaza, Lake Buena Vista. For information: Lamar Crevasse, M.D., Box J-233, JHM Health Center, Gainesville 32610.

The ABC's of Viral Hepatitis, Nov. 19, Ft. Cooper Station Restaurant, Inverness. For information: C. J. McGrew Jr., M.D., 2875 Keyville Avenue, Spring Hill 33526.

Multiple Sclerosis Update for Physicians in Practice, Nov. 20-23, Walt Disney World Conference Center, Lake Buena Vista. For information: Allen D. Roses, M.D., Professor and Chief, Division of Neurology, Duke University Medical Center, Durham, N.C. 27710.

DECEMBER

American Cancer Society — National Conference Gastrointestinal Cancer, 1981, Dec. 8-10, Fontainebleau Hilton Hotel, Miami Beach. For information: Nicholas G. Bottiglieri, M.D., American Cancer Society, National Conference, Gastrointestinal Cancer, 1981, 777 Third Avenue, New York, New York 10017.

*The deaf students at
the Joffrey Ballet School
learn to dance by responding
to the vibrations of the music.*

President's Committee on
Employment of the Handicapped
Washington, D.C. 20210

1981. The International Year of Disabled Persons.

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on
standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC. 
2500 West Sixth Street, Los Angeles, California 90057

NME
can set
up the
practice
you want.

In the area
you want.

It's a goal we achieve by offering you a choice of over 60 well equipped acute care hospitals coast to coast; by offering you selected financial assistance, and by offering you management consulting when you begin your practice.

At National Medical Enterprises, we'll help you establish a comfortable and successful Primary Care practice.

Where you want it.

How you want it.

So whether you're interested in a solo, partnership, or a group practice, you should contact NME.

We're the experts.

For further information, contact:
 Raymond C. Prulitt, Director Physician Relations
 National Medical Enterprises
 11620 Wilshire Blvd., Los Angeles, California 90025.
 Call Toll-Free 800-421-7470
 or collect (213) 479-5526.

NATIONAL MEDICAL
ENTERPRISES, INC.



"The Total Health Care Company."
 An Equal Opportunity Employer M/F

FLORIDA PUBLIC HEALTH ASSOCIATION, INC.

ANNUAL EDUCATIONAL CONFERENCE

"PREVENTION NOW"

Featured Speaker: William Foege, M.D., M.P.H., Assistant Surgeon General and Director, Centers for Disease Control, U.S. Public Health Service, Atlanta, Georgia. Dr. Foege will speak on "The Second Revolution in Public Health".

Other Speakers: Florida Department of Health and Rehabilitative Services Secretary — Alvin J. Taylor and Florida Representative — Beverly Burnsed.

Meeting Site: Galt Ocean Mile Hotel, 3200 Galt Ocean Dr., Ft. Lauderdale, Florida 33308. Phone: (305) 564-8581.

Rates: \$28/30.

C.E.U.s: Pending approval.

FPHA Membership Application and More Information:

FPHA, Inc.
 Post Office Box 14608
 Ft. Lauderdale, Florida 33302

Familial Ovarian Cancer Registry



There are increasing reports of ovarian cancer occurring in two (2) or more family members. The Familial Ovarian Cancer Registry will evaluate this increase to obtain information for genetic counseling to family members. Case accrual will evaluate:

- the number of cases of familial ovarian cancer
- the type of inheritance
- the relationship to breast and endometrial carcinoma
- the study of environmental, geographical and racial factors
- genetic counseling.

Please address inquiries regarding the clinical history of any family with two (2) or more members with ovarian cancer to:

Familial Ovarian Cancer Registry
 M. Steven Piver, MD • Roswell Park Memorial Institute
 New York State Department of Health • 666 Elm Street
 Buffalo, New York 14263
 Telephone: (716) 845-3110

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

MEDICAL OPHTHALMOLOGIST wanted for busy practice. No refraction or contact lens fitting. Ideal location in East Coast of Florida. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

FAMILY PRACTITIONER OR INTERNIST needed to join staff of a Family Medical Center in North Florida. Excellent opportunity for professional and economic growth. Respond with CV to: Susan Masterson, Emergency Medical Services Associates, Inc., 8200 W. Sunrise Blvd., Building C, Plantation, Florida 33322, or phone (800) 327-0413. In Florida call (305) 472-6922.

FLORIDA — Aggressive group, fee-for-service, malpractice, group health insurance, teaching, EMS, opportunity for advancement. Contact Steve Watsky, M.D., 707 40th Street West, Palmetto, Florida 33561, (813) 722-1722 or P. Fagan Jr., M.D., Post Office Box 9639-FL, Marina Del Rey, California 90291, (213) 822-1312.

EMERGENCY MEDICINE opportunities throughout Florida: Directorship and clinical positions available to career-oriented emergency physicians in central and coastal areas. Excellent compensation, paid professional liability insurance, flexible scheduling to be awarded to physicians chosen. For details send credentials

in complete confidence to Mary Obsitnik, 9100 Purdue, Suite 119, Indianapolis, IN 46268; or call collect (317) 875-7518.

FP's NEEDED for ideally located office in north Palm Beach County, (Jupiter-Tequesta area). Also, space for ophthalmologist or dermatologist. Coverage and assistance available. Two open staff hospitals nearby for qualified M.D.'s. Call: (305) 746-2033.

CHATTANOOGA, TENNESSEE — New Hospital recruiting one Family Practitioner, and one E. R. Physician to join established groups. Two additional Family Practitioners needed to develop a group practice in an under-doctored community (unique financial opportunity). One full-time Anesthesiologist needed for hospital (salary negotiable). All applicants must be board eligible, or certified for the above positions. If you want seasonal changes, excellent schools, a very low cost of living, and be close to Atlanta, Nashville, or the Smokey Mountains, this is an excellent opportunity. Please send your curriculum vitae with references to: C-1059, Post Office Box 2411, Jacksonville, Florida 32203.

PSYCHIATRIST OPENINGS at Northeast Florida State Hospital near Jacksonville. Position as Service Center Directors, as Staff Psychiatrists, and also as physicians are now available. Assignments on General Adult Psychiatric Service, Geriatric Service, and Children's Service as well. Competitive salary and benefits. Affiliation with the University of Florida, Gainesville, EEO/AA. Please contact Clinical Director, Northeast Florida State Hospital, Hwy. 121, S., Macclenny, Florida 32063 or call (904) 259-6211, ext. 110.

POSITION AVAILABLE AS MEDICAL DIRECTOR for the Ft. Lauderdale Inter-Continental Hotel and Spa at Bonaventure. Background and interest in sports medicine as well as nutrition preferred. Write C-1063, P.O. Box 2411, Jacksonville, Florida 32203.

MULTI-SPECIALTY GROUP PRACTICE now being formed in new medical center in West Palm Beach, Florida. Will

open on or about March 1982. High income potential, salary and profit sharing. Positions still available. If interested, please forward resume to Mathew I. Gelfand, M.D.P.C., 718 East Park Avenue, Long Beach, New York 11561.

COMPHEALTH - LOCUM TENENS — Physicians covering physicians, nationwide, all specialties. We provide cost effective quality care. Call us day or night. T.C. Kolff, M.D., President, Comphealth, 175 West 200 South, Salt Lake City, Utah 84101, (801) 532-1200.

PHYSICIANS WANTED: non-clinical disability evaluation medical consultation for Social Security. Full time, 40 hour work week. Knowledge of electrocardiographic interpretation desirable. Write or call G. M. Davis, State Medical Consultant, 3437 Lawton Road, Suite 127, Orlando, Florida 32803; (305) 896-4691.

FAMILY PRACTITIONER OR INTERNIST WANTED to provide a fee for service type of care for a large St. Petersburg condominium complex and surrounding area. A spacious medical center is available with five nurses providing 24 hour service. Ideal for a retired physician. Contact T. R. VanDell, M.D., 5200 Brittany Drive South, St. Petersburg, Florida 33715 or call (813) 867-3513.

WANTED: fulltime internist-general practitioner. NW Broward area — Fort Lauderdale, Florida. Call (305) 973-1600.

LOCUM TENENS one year. Established internist's practice. Ideal East Central Florida beach area. Can become permanent. Send C.V. Reply: C-1066, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIANS WANTED! Non-clinical disability evaluation medical consultation for Social Security. Fulltime 40 hour work week. Knowledge of electrocardiographic interpretation desirable. Write or call Dr. George Davis, State Medical Consultant, 3438 Lawton Road, Suite 127, Orlando, Florida 32803. Phone (305) 896-4691.

EMERGENCY DEPARTMENT PHYSICIAN needed to join established group in North Central Florida. Paid malpractice, profit sharing and pension plan second year. 28 hour work week. Good salary first year. Contact R. W. Carr, M.D., 9900 N.W. 115 Avenue, Ocala, Florida 32671.

INTERNIST WANTED to join two well-established physicians in busy internal medicine practice in Miami Beach. Top hospital affiliations, prestigious location. Contact or send C.V. to Lewis R. Elias, M.D. and Paul Rozynes, M.D., 10295 Collins Avenue, Bal Harbour, Florida 33154.

LOCUM TENENS in Diagnostic Radiology with Ultrasound capabilities. Two week minimum. Florida license required. ABR certified or eligible. Send C.V. with inquiry to Drs. Plenge and Bedoya, 600 North Church Street, Lake City, Florida 32055, or call collect after hours (904) 755-2235.

STAFF PSYCHIATRIST position open. Mental Health Clinic of Jacksonville, Inc., 2627 Riverside Avenue, Jacksonville, Florida 32204. Phone: 384-2364. Must be Board Eligible/Certified and have Florida License. Staff of 10 professionals. Clinic is strictly an adult outpatient non-profit corporation. Benefits include 15 days paid vacation, Major Medical Insurance, and Retirement program. Salary negotiable. The Clinic is an Equal Opportunity Employer.

OBSTETRICIAN / GYN COLOGIST — South Central Florida — Excellent solo opportunity with good coverage for OB/GYN with Florida license in community of 25,000 with a service area population of 50,000. New 75 bed, full service hospital. Office space available in new professional building next to hospital. Area unsurpassed in natural beauty and recreational activities. Extremely high earnings potential. Send C.V. to Jim Butler, Manager, Medical Relations, Hospital Corp. of America, One Park Plaza, Nashville, Tennessee 37203, or call toll free (800) 251-2561.

ORTHOPEDIC SURGEON needed — West Coast of Florida. Guaranteed income and relocation expenses available. Please submit C.V. to C-1067, P.O. Box 2411, Jacksonville, Florida 32203.

RAPIDLY GROWING 23 man multi-specialty group on Florida's Treasure

Coast, will add a well trained Family Practitioner to its 5 man Family Practice Department. Please send C.V. to C-1065, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIAN WANTED for diagnosis, treatment and patient care in general medicine in a medical clinic environment. Requires M.D. Degree and three years experience. 40 hours per week, good salary. Contact Florida Division of Employment Security, P.O. Box 3545, West Palm Beach, Florida 33402. Telephone: (305) 689-4241.

Situations Wanted

GENERAL, COLON AND RECTUM SURGEON, trained in Colonoscopy, Board eligible, 35, seeks position in Florida to practice either one specialty or both. Speaks Spanish fluently. Available October 1981. Contact: Luis F. Espallat, M.D., 1517 Texas Avenue, Homestead AFB, Florida 33039. Phone (305) 257-2870.

BOARD CERTIFIED (AP & CP). Experienced. Seeking the position of hospital based associate or assistant pathologist in the Florida State. Available immediately. Contact: C-1060, Post Office Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON, 34, board qualified, with Florida license, seeking relocation. All areas considered. Reply: A. Gutierrez, M.D., 213 W. New Jersey Ave., Somers Point, New Jersey 08244. Phone: (609) 653-1117.

BOARD CERTIFIED FAMILY PRACTITIONER; Board Eligible ER; clean record 23 years experience desires full or part time salary position in clinic, ER, or teaching in Central or N.E. Florida. Write C-1064, P.O. Box 2411, Jacksonville, Florida 32203.

OPHTHALMIC TECHNICIAN, 37, Air Force retiree. 15 years clinical and surgical experience, excellent references. Desires position Spring '82 in northern Florida. Dennis Hanyo, 301 Granger Circle, WPAFB, Ohio 45433.

EXPERIENCED PATHOLOGIST and nuclear medicine physician. Will be available to change positions with six months notice. Board certified in AP, CP, NM and FP. Write Marvin Johnson, M.D., 900 Avenue M, Southeast, Winter Haven, Florida 33880.

Practices Available

PRACTICE FOR SALE — 3½ years. General Internal Medicine; active; Office adjacent to 350-bed hospital. Negotiable terms. Call (813) 522-4611 after 7 p.m.

FAMILY PRACTICE IN BROWARD COUNTY. Leaving after one year for university appointment. Attractive office in family neighborhood. Available now and very reasonably priced. This practice is new and can become what you want it to be. Contact I. Streiff, M.D., 8021 Kimberly Boulevard, North Lauderdale, Florida 33068. Call after 7 p.m. (305) 752-8321.

MIAMI: FAMILY PRACTICE. Good gross in fully equipped office with x-ray. Long established in South Dade, excellent opportunity for right person, G.P. or internist. Write with C.V. to Post Office Box 970994, Miami, Florida 33197. (M.D. is ill.)

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

FORT LAUDERDALE: OUTSTANDING LOCATION: Two offices with attached elegant home, which is convertible to clinic, 5,200 square feet, corner, good parking. Opposite Galleria Shopping Center, good terms. 2600 N.E. 9th Street, (305) 561-3843.

LAGO VISTA EXECUTIVE CENTER, 8019 N. Himes Avenue, Suite 300, Tampa, Florida 33614. 1,500 square feet, suitable for doctor. Quiet, pleasant atmosphere, overlooking landscaped lake. Convenient location. (813) 933-5100.

OCALA — CENTRAL FLORIDA — Modern building in tremendous location. Ready for occupancy. Contact Dr. Robert Dreyfus, (904) 732-0318 or (904) 732-5555.

SUITE FOR RENT — Centrally located medical building. 1,050 sq. ft. of office space. Family practice, internist or subspecialist. Write or call Lincourt Medical Center, 501 S. Lincoln Ave., Clearwater, Florida 33516. (813) 446-3851.

CONDOMINIUM for rent St. Thomas U.S.V.I. on the Caribbean, two bedrooms, two bathrooms, three pools, free tennis, reduced airfares. Still available for Perinatology meeting November 15th through the 21st. List of other meetings available. Call Dr. Blondy collect at (313) 478-2739.

HOUSE FOR SALE — Venice/Englewood, Florida. Prestigious Williamsburg style home, 4 bedrooms, 3 bathrooms, screened pool. Secluded 2 acre wooded lot, convenient to beaches, golf, shopping. Excellent schools. \$215,000.00. Call or write: (813) 474-8570, 1185 Larchmont, Englewood, Florida 33533.

OUTSTANDING LOCATION FOR GROUP PRACTICE, Jacksonville. Center of medical area in Riverside. Ideal for medical group practice. Available for purchase. For details call or write owner's attorney, Anthony F. Marinucci, P. O. Box 4255, Jacksonville, Florida 32201. Phone (904) 355-2277.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Co., 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Services

DOCTOR, WE KNOW YOUR BUSINESS. With 27 years experience as a hospital administrator and being raised in a Doctor Family, Bill Bishop, FACHA, understands your needs! He specializes in recruitment and placement of doctors in Florida. Bill Bishop and Associates, Inc., Health Care Executive and Physician Search Consultant, 1045 Riverside Ave., Jacksonville, Florida 32204, (904) 354-1050.

TUITION ASSISTANCE PROGRAM, INC., P. O. Box 6221, Duluth, MN 55806. Matching communities-seeking physicians with physicians-in-training requiring tuition assistance. Keith Hummel, Director. Write for more information.

STATIONERY CUSTOM DESIGNED — Eye-catching professional stationery at discount prices to doctors and their wives. Unique calling cards, letterheads, greeting cards, announcements and professional courtesy gift presentations to your order. Call (305) 661-6777. Papers by Gloria and Sue, 465 Rovino Avenue, Coral Gables, Florida 33156.

Equipment

FOR SALE — Pelton and Crane autoclave, Triac centrifuge, Doctor's office and exam room furnishings. Call (305) 282-0583.

WE BUY, SELL, LEASE new and used medical instrumentation — EKG's, Laboratory, Holters, Scanners, Stress Test, Echocardiographs, etc. Contact: New Life Systems, Inc., Edgar Bentolila, P.O. Box 8767, Coral Springs, Florida 33065. Phone (305) 753-9961.

Meetings

SNOWMASS/VAIL "MEP" SKI SEMINAR on management Enrichment for the Health Professional. Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or Ski Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Seminars comply with IRS rules to make trip expenses deductible for doctor and spouse. For brochure and lodging information contact: M.E.P., An Education Corporation, 906 Cooper Ave., Glenwood Springs, Colorado 81601; or call (800) 525-3402.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

UNIVERSITY PHYSICIAN (STUDENT HEALTH SERVICE)

University of Florida

Position requires a medical degree from a recognized medical college plus completion of one year of internship, in addition to two years of residency in a recognized specialty, or four years of general practice. Board certification or eligibility in Family Practice, Pediatrics, Internal Medicine, or other specialty area preferred. Must be licensed in the State of Florida. Experience in athletic medicine desirable. Negotiable salary plus excellent fringe benefits. Submit resume by October 8, 1981 to:

Mr. George P. Bradley
Employment Manager
337 Stadium
University of Florida
Gainesville, FL 32611

EQUAL EMPLOYMENT OPPORTUNITY/
AFFIRMATIVE ACTION EMPLOYER.

Advertisers

Brown Pharmaceuticals		Florida Public Health Association, Inc.	
Cerebro-Nicin	784	Meeting	786
Lipo-Nicin	785	Smith Kline and French	
Android	700	Dyazide	702a
Burroughs Wellcome		Spectrum Emergency Care, Inc.	
Neosporin Topicals	782a	Service	777
Cary Martin		Roche Laboratories	
Decorating	782	Valium	686
DAC Corporation		Bactrim	791
Service	778	Librax	702a
Florida Medical Foundation		University of Florida	
Citrus and Seafood	701	Meeting	777
Florida National Banks		Recruitment	789
Service	688	University of Miami	
Geriatric Pharmaceutical Co.		Meetings	778
Iso-Bid	692	The Upjohn Company	
Hospital Corporation of America		Motrin	702a
Recruitment	777	Wetzel	
Eli Lilly & Company		Service	689
Keflex	702	Willingway Hospital	
Merrell Dow Pharmaceuticals		Service	700
Bentyl	696	Wyeth Laboratories	
Quinamon	782a	Cyclapen-W	699
National Medical Enterprises		Eguagesic	782a
Service	786	Wygesic	782a

Florida Medical Association Officers and Council Chairmen

Officers

Sanford A. Mullen, M.D., Jacksonville, President
 Robert E. Windom, M.D., Sarasota, President-Elect
 Gerold L. Schiebler, M.D., Gainesville, Vice President
 Luis M. Perez, M.D., Sanford, Secretary
 J. Russell Forlaw, M.D., Boynton Beach, Treasurer
 T. Byron Thames, M.D., Orlando, Immediate Past-President
 James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
 Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
 W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
 Louis C. Murray, M.D., Orlando, Legislation
 Charles P. Hayes, M.D., Jacksonville, Health Care Financing
 Joseph T. Ostroski, M.D., Miami, Medical Services
 Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
 Arthur L. Eberly, M.D., Lighthouse Point, Specialty Medicine

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION INC.

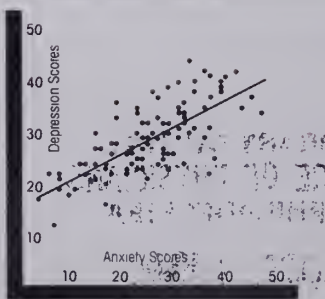
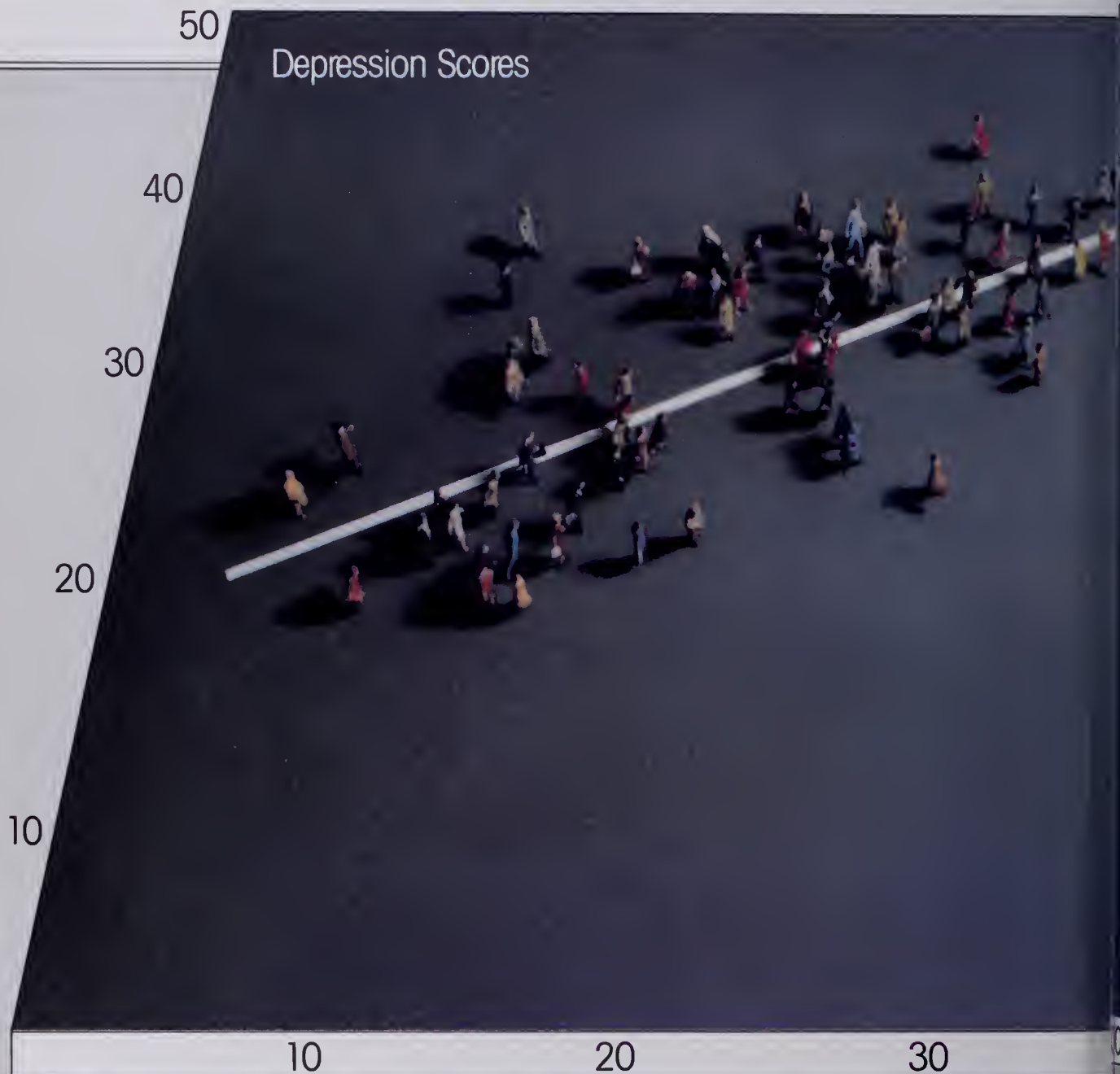


OCTOBER 1981 • VOL 68 • NO. 10

VII

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
OCT 30 1981

FOR THE 7 OF 10 NONPSYCHOTIC



Clear correlation between anxiety and depression³

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

³Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics* 11:438-441, Sept-Oct 1970.

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS^{1,2}

Most depressed patients are also anxious. . .

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.^{1,2} One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.³ As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.⁴ Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.⁵ Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. 2. Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry* 35:1359-1365, 1978. 3. Claghorn J: The anxiety-depression syndrome. *Psychosomatics* 11:438-441, 1970. 4. The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry* 137:1163-1172, 1980. 5. Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology* 61:217-225, 1979.

Anxiety Scores

50

In moderate depression and anxiety

Limbitrol[®] ^{IV}

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

OCT 30 1981

LIMBITROL® TABLETS Tranquillizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief at moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies.

Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecostasia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage at three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles at 100 and 500; Tel-E-Dose® packages at 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks at 50.

The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment



**CONVENTION
PRESS, INC.**

2111 NORTH LIBERTY ST.
**JACKSONVILLE,
FLORIDA 32206**

PHONE 904/354-5555



ROCHE PRODUCTS INC
Manati, Puerto Rico 00701



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

OCTOBER 1981 • VOL 68 • NO. 10 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.
E. Charlton Prather, M.D.

Assistant Editors

Francis C. Coleman, M.D.
James K. Conn, M.D.
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
Norman M. Kenyon, M.D.
(from Board of Governors)
Edward Pedrero Jr., M.D.

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Susan L. Milhoan

Consulting Editorial Staff

Fuad S. Ashkar, M.D.	Karl J. Kramer, M.D.
Thomas D. Bartley, M.D.	R. G. Lacsamana, M.D.
Robert L. Batey, M.D.	Richard F. Lockey, M.D.
Pierre J. Bouis Jr., M.D.	Philander D. Morgan, M.D.
Ms. Deborah B. Wilbur	George Morris, M.D.
William T. Branch, M.D.	George A. Neder Jr., M.D.
Miguel A. Brito, Jr.	Richard S. Panush, M.D.
Elmer B. Campbell, M.D.	R. A. Penalver, M.D.
Manuel L. Carbonell, M.D.	John K. Petrakis, M.D.
Ronald W. Case, M.D.	Phillip B. Phillips, M.D.
Toni Charneco	Michael R. Redmond, M.D.
Louis E. Cimino, M.D.	Albert L. Rhoton, M.D.
Charles Craig, M.D.	James F. Richards Jr., M.D.
R. Jay Cummings Jr., M.D.	Arvey I. Rogers, M.D.
Raul deVelasco, M.D.	William J. Romanos Jr., M.D.
James E. Deming	Lees M. Schadel, M.D.
Pablo Enriquez, M.D.	Frederick W. Schert, M.D.
Robert F. Feltman, M.D.	Guy T. Selander, M.D.
Richard Feinstein, M.D.	Roberto A. Sosa, M.D.
Lawrence M. Fishman, M.D.	John Stone, M.D.
Allan L. Goldman, M.D.	Robert H. Threlkel, M.D.
Henry L. Harrell, M.D.	Benjamin E. Victorica, M.D.
Allan Herskowitz, M.D.	Thomas M. Wiley, M.D.
James T. Howell, M.D.	Charles D. Williams, M.D.
Rubin Klein, M.D.	Frederic C. Wurtzel, M.D.

Subscription Rate: \$15.00 per year, single copy \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917: authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

Scientific Articles

- 813 Aerospace Medicine, Central Florida, 1981
Paul Buchanan, M.D.
- 816 A Case of Shellfish Associated Cholera
in South Florida
*G. E. Rodrick, Ph.D., M. Lotz, M.D.,
N.G. Alexiou, M.D., and J. Ambrusko, M.D.*
- 819 Lithium: Overview of Practical Considerations
*Carlos E. Muniz, M.D., Louis J. Perillo, M.D.,
Anthony G. Troiano, M.D., and Mark H. Binus, M.S., R.Ph.*
- 823 Encephalopathy Secondary to Abusive Gasoline Inhalation
Leon D. Prockop, M.D., and Dean Karampelas, M.D.
- 825 Congenital Listeriosis
S. C. Huang, M.D.

Special Articles

- 827 National Institutes of Health Consensus
Development Conference Statement
*Coronary Artery Bypass Surgery:
Scientific and Clinical Aspects*
- 833 Three Commentaries on the Consensus Conference on
Coronary Artery Bypass Surgery
- 837 What Became of the Rotating Internship?
Richard A. DeRemee, M.D.

Editorial

- 809 Medicine's Spinoffs Alone Justify Space Program
Joseph C. Von Thron, M.D.

Departments

- 799 The President's Page
The United States Space Program
Sanford A. Mullen, M.D.
- 810a Gray Paper
- 811 Professional Liability Legal Update
Informed Consent — Prescription of Drugs
- 839 Organization
*Florida Legislature to Convene Early;
FMA Legislative/FLAMPAC Workshop Planned*
- 840 Correspondence
- 842 Medical News Around the State
- 844 Information for Authors
- 845 FMA Auxiliary
FMAA News Capsules . . .
- 847 Book Reviews
- 852 Meetings
- 855 Classified Advertising
- 858 Index to Advertisers
- 858 FMA Officers and Council Chairmen

Cover

The cover this month features a photograph taken by FMA President Sanford A. Mullen, M.D., of the April 12, 1981 launching of the Space Shuttle Columbia. The second launching of the Columbia will take place in early October, and in recognition of this fact, The Journal has devoted several pages within this issue to the topic of aerospace medicine. (See pages 799, 809, and 813).

COMPARE:

**All medical malpractice
insurance coverage is
NOT THE SAME!**

- Your Reciprocal specializes in one line of insurance in one State — Florida.
- Profits derived from its operation are returned to its physician owners — not foreign stockholders.
- Each member has ready access to its Board of Directors — all Florida physicians.
- Was formed to provide you with coverage when no commercial company would write a Florida physician.

**FLORIDA
PHYSICIANS'
INSURANCE**

RECIPROCAL

1000 Riverside Ave. / P. O. Box 40198 / Jacksonville, FL 32203

Telephone (904) 354-5910 / Wats 1-800-342-8349



President's Page

The United States Space Program

A short time after dawn on Sunday morning, April 12, 1981, it was my privilege to be present at a point approximately one mile from the launch site of the first space shuttle, the Columbia, as it lifted off on its historic voyage. Thanks to the efforts of Dr. L. E. McHenry of Melbourne, I was able to be among the group of spectators who saw the launch from inside the Kennedy Space Center. Although, like many other Americans, I had watched multiple space shots on television and had become rather blasé about rockets blasting into space, this was my first experience from such a vantage point. The almost unbearable tension as the final countdown reached the last seconds prior to ignition and lift-off literally electrified the crowd of onlookers. Most of the spectators had their own portable radios and there was also a very excellent public address system giving all of the details of precisely what was going on as the assembled multitudes watched the immobile Columbia as it sat perched on its launch pad awaiting the beginning of its flight.

As we watched, a sudden hush came over the crowd during the final seconds before lift-off. The signal for ignition with the resulting vapor cloud followed by the flames of the rockets, as the spacecraft moved slowly, almost reluctantly, upward from its pad on the first step of its journey into space, had everyone's heartbeat at a record high. Although we were a mile from the launch pad, the noise was unbelievably loud and, when it and the pressure of the shock waves from the blasting rockets reached us, the sensation was one of being physically pushed-back as the spacecraft lifted-off its pad.

As the Columbia began to move upward, its speed rapidly accelerated and the crowd broke into spontaneous applause and cheering while a few spectators who had American flags waved them vigorously. Within a matter of seconds the spacecraft was well on its way and had disappeared from sight. This short period of time provided a moment of rare exhilaration for all who were present. A surge of pride at being Americans and being

part of the space effort was readily apparent as animated conversations were exchanged between total strangers as well as between friends and relatives.

As those of you who have been in the space center at the time of a launch will recall, there is a period of one hour after the lift-off during which no one is allowed to leave the area from which he or she has been watching the proceedings. During this time nearly everyone listened to his or her radio and continued the discussions of the awe-inspiring sight which they had just observed. During this waiting period all were quick to agree that whatever effort had been made to get to the space center to watch the space shot was well worth the effort. People had come from all over the country for a spectacle that lasted less than 60 seconds but one which will last in the minds of all eyewitnesses for the rest of their lives.

The experience of being present at the launching of the space shuttle is a rare treat and one which will naturally cause an individual to think more about the space program in general. The space program has made a major fiscal impact on the State of Florida. The Kennedy Space Center has become one of the greatest tourist attractions in the state and has had millions of visitors from all over the world during the years it has been in existence. The development of the space program has led to extensive development in and around Cape Canaveral with multiple support businesses developing into many major industrial complexes. All would concur that the space program has been of immeasurable financial benefit to the entire State of Florida.

It would be difficult to justify the existence and further development of a space program by the United States if it were based on the facts that the space center is a great tourist attraction and the space program has resulted in great financial benefits to the State of Florida. There are, however, many more benefits which have come not only to Florida but to the entire United States and even to the world by virtue of the United States

program.

The National Aeronautics and Space Administration (NASA), as we have all learned, is the federal agency responsible for operating the space program. For several years it has published an annual report entitled *Spinoff* which describes the new products and processes which have been developed due to technology originally developed because of the needs of the space program. Actually thousands of such spinoffs have occurred. Congress has mandated that NASA must promote expansion of these technical advances in the public interest. The technical advances made because of the space program provide ample reasons for the continuation of the program.

Dr. Joseph C. Von Thron of Cocoa, a Past President of the Florida Medical Association, has written an editorial for this issue of *The Journal of the Florida Medical Association* concerning a few of the medical spinoffs which have resulted from the scientific breakthroughs in the NASA program. Dr. Von Thron illustrates clearly that the medical spinoffs alone justify the space program.

There have been many spinoffs which benefit mankind in addition to those related to the field of medicine. NASA has learned a great deal about the conservation of energy, particularly as it relates to space flight but also as it relates to conventional flying by commercial airlines. The development of communication systems has been largely through the efforts of NASA and has resulted in the high degree of sophistication in communications which we now take for granted. The use of solar energy is being rapidly developed by use of technology which had its origins and continuing development in the space program.

Through space technology it is possible to have much more precise inventories of land uses in the United

States and over the world. Satellites will be able to determine the production of various crops throughout the world and enable the United States Department of Agriculture to make well-informed decisions as to commodity price programs, export strategies and the level of grain and other reserves. This could prove to be the basis for an extremely important form of leverage for the United States in dealing with other countries around the world.

The space program has led to the development of fabrics which are extremely effective in the retention of body heat. The list of new items resulting from space technology is virtually limitless. The interested reader is encouraged to obtain a copy of *Spinoff 1981* which is sold by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

The cover and a major part of this issue of *The Journal* are devoted to the space program. In addition to the editorial by Dr. Von Thron, mentioned previously, there is an excellent article by Dr. Paul Buchannan describing aerospace medicine. The thrust of this issue is designed to call attention to the widespread benefits of the space program to Florida, to the United States and to mankind in general.

Although some individuals might believe that the dollars expended in the space program would produce greater benefits if they were used in direct social benefit programs, this is simply not the case, because of the spinoffs from the space program which have resulted in far greater benefits to all of mankind. We urge that the space program not be unwisely reduced in an effort to save dollars for the present because experience has shown that the space dollar produces a great positive financial impact on our entire nation and will do much to improve the quality of life of all of us.

Sanford A. Pullen, M.D.

FOR OPTIMUM NUTRITION

CEVI-BID

VITAMIN C

MICRO-DIALYSIS

SUSTAINED RELEASE

500mg. CAPSULES

PROVIDES A

"MORE SATISFACTORY TREATMENT..."¹

HERE'S WHY

ORDINARY VITAMIN C INTAKE:

Results in "peaks and valleys"

(wasteful renal excretions at high levels and less than optimum amounts of vitamin C at low levels)

Absorption of enteric-coated vitamin C tablets is also unpredictable.

"Through a special micro-dialysis release pattern we find it CEVI-BID far better therapy than tablets for the patient."²

CEVI-BID 500mg CAPSULES:

Convenient b.i.d. dosage for more predictable sustained vitamin C blood and tissue levels all day and night. No "peaks and valleys."

"A special advantage of this prolonged absorption period results in the maintenance of blood levels throughout the day and night."²

CEVI-BID's unique micro-dialysis principle provides release of 500mg of vitamin C during a 12 hour period
AT A SMOOTH, UNIFORM RATE.

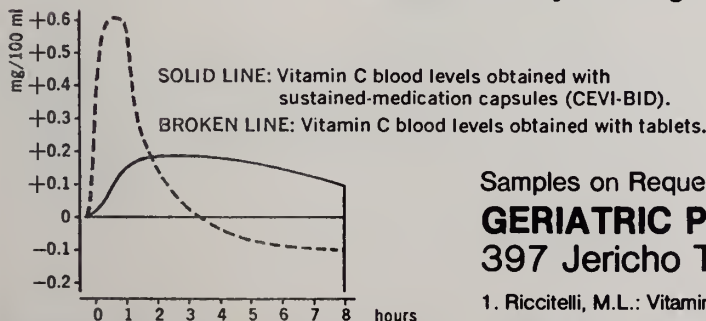
CEVI-BID..."provides a more satisfactory treatment of disorders requiring administration of vitamin C in repeated doses of relatively small amounts."¹



WHENEVER VITAMIN C IS INDICATED...PRESCRIBE CEVI-BID

Dosage: For continuous 24 hour therapy, one capsule after breakfast and one after supper.

Available Only Through The Medical Profession



*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules).
*Adaptation

Samples on Request

GERIATRIC PHARMACEUTICAL CORP.

397 Jericho Turnpike, Floral Park, N.Y. 11001



1. Riccitelli, M.L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20:34, 1972.

2. Riccitelli, M.L.: Vitamin C—A Review. Conn. Med. 39:609, 1975

DEVELOPERS AND SUPPLIERS OF GER-O-FOAM • GAYSAL • B-C-BID

DOCTORS ARE DIFFERENT

They know to send only the finest, most **healthful** gifts for Christmas. No sugar-laden candies will do. So this year, let Florida's Finest Citrus and Gourmet Seafood top your shopping list, and at the same time support the Florida Medical Foundation.

We have again made a special arrangement with one of Florida's finest groves to offer you the top 1% of their entire crop — all superior quality fruit, for your gift-giving this year. This fruit is picked, packed and shipped the same day to ensure freshness. It is brimming with **natural** sweetness, and therefore, is the most **natural** gift for all your gift giving.

Order Pak #30 (½ Bushel) — \$17.95 or Pak #55 (1 Bushel) — \$26.95. You may select all oranges, all grapefruit or our special mix of ½ each fruit. For complete selection, write or call for our free brochure. (Don't forget to ask for our Gourmet Seafood Brochure, also).

Ask about our Six Month Fruit Plan, or our Three Month Fruit Plan, too. Brochures may be obtained from your local Chairman, or from:

Florida Medical Association Auxiliary
Mrs. David Whittaker
1140 S.E. Fort King
Ocala, Florida 32671

Benefits go to the Florida Medical Foundation. Make checks payable to: "FMA-Auxiliary-FMF".

Please ship the following to my family and/or friends:

Name: _____

Address: _____

Pak #30 (½ Bushel) _____ Pak #55 (1 Bushel) _____

All Oranges _____ All Grapefruit _____ Or Mix _____

Compliments of: _____

Price: _____ Arrival Date: _____

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any anxiolytic agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg end higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chloridiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, beer in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan[®]
for (lorazepam)
Anxiety

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.



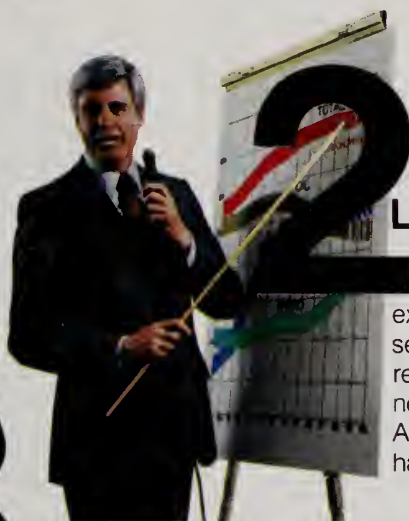
Four practical reasons to prescribe **Ativan®** **for** (lorazepam) **Anxiety***



1

No interaction with more than 300 drugs[†]

In clinical studies, Ativan was given concomitantly with hundreds of medications, including gastrointestinal and cardiovascular, with no reported interactions. Whereas the interaction of diazepam and cimetidine has been shown to cause increased sedation in patients taking both drugs, the clearance of Ativan is not delayed by Tagamet.[‡]



2 Lets most patients stay active

Long-acting benzodiazepines have long-acting metabolites with activity which can produce excessive accumulation that may lead to unwanted sedation. Ativan® has no active metabolites, reaches steady state in 2 to 3 days and usually does not cause oversedation. Also, the shorter half-life of Ativan is consistent with b.i.d. dosage, so drug hangover is seldom a problem the next morning.



3

Not appreciably affected by aging

Unlike the long-acting benzodiazepines—diazepam®, chlordiazepoxide®, clorazepate®, and prazepam®—the metabolism and clearance of Ativan are not appreciably affected by the aging process.



4

Not significantly affected by liver dysfunction

Ativan® is metabolized in one simple step to an inactive glucuronide; its absorption and excretion are not significantly altered by cirrhosis or hepatitis. By contrast, the metabolism of diazepam and chlordiazepoxide has been reported to be significantly altered in patients with liver dysfunction.

* Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic.

† All benzodiazepines, however, produce additive effects when given with CNS depressants, such as barbiturates or alcohol.

‡ Tagamet (cimetidine) is a registered trademark of Smith Kline & French Laboratories, Division of SmithKline Corporation.

Copyright © 1981, Wyeth Laboratories. All rights reserved.

See important information on following page.

Wyeth Laboratories
Philadelphia, PA 19101



TM

THE AMERICAN MEDICAL EEG ASSOCIATION PRESENTS:

The third annual "Electroencephalography Review and Overview" to be held in Jacksonville, Florida, at the Jacksonville Hilton, Saturday and Sunday, November 14-15, 1981. This course is sponsored by the American Medical EEG Association, Co-sponsored by St. Vincent's Medical Center, and The Florida Neurological Institute, Inc., Jacksonville, Florida and is approved for 15 hours of category I CME credit.



SATURDAY

John Hughes, M.D., Professor of Neurology, University of Illinois School of Medicine, Chicago, Illinois — **"Maturational Change of the Infant EEG"**

James G. T. Nealls, M.D., Clinical Assistant Professor of Pediatric Neurology, University of Florida School of Medicine, Jacksonville, Florida — **"Abnormalities Encountered in Pediatric EEG Practice"**

Professor Henri Gastaut, Professor of Neurology, Hospital De La Timone, Marseille, France (Sponsored by Florida Neurological Institute, Jacksonville, Florida) — **"Benign Epilepsy of Children with Occipital Spike and Wave"**

Reginald Bickford, M.D., Professor of Neurosciences, University of California at San Diego, San Diego, California — **"Epileptic Triggers and the Use of Computers in EEG"**

Harley E. Schear, M.D., Associate Chief, Neurosciences, Mt. Zion Hospital and Medical Center, San Francisco, California — **"The Significance of the Generally Slow EEG"**

J. Garvin, M.D., Professor and Chairman, Department of Neurology University of Illinois School of Medicine, Chicago, Illinois — **"The Significance of Focal Slowing on the EEG"**

***Frederic Gibbs, M.D.**, Professor Emeritus, Department of Neurology, University of Illinois School of Medicine, Chicago, Illinois, joined by **Reginald Bickford, M.D.** and **Henri Gastaut, M.D.** — **"How to Interpret the EEG"**. A panel discussion.

*Individual EEG Interpretation (small group participation) by Drs. Gibbs, Gastaut and all speakers. Round Table Discussion — Bring your own EEGs

SUNDAY

Timothy Pedley, M.D., Associate Professor of Neurology, Columbia University College of Physicians and Surgeons, New York, New York — **"EEG Patterns of Uncertain Significance"**

B. J. Wilder, M.D., Professor of Neurology, University of Florida School of Medicine and Chief of Neurology Service, VA Medical Center, Gainesville, Florida — **"The Therapy of Epilepsy"**

Robert Weinmann, M.D., Associate Editor, *Clinical EEG*, San Jose, California — **"Brain Death, EEG vs Evoked Potential"**

Roger Cracco, M.D., Professor and Chairman, Department of Neurology, SUNY Downstate Medical Center, Brooklyn, New York — **"Somatosensory Evoked Potentials as an Important Neurodiagnostic Technique"**

Irvin Gerson, M.D., Assistant Professor, Department of Psychiatry and Human Behavior, Jefferson University, and Director of Neurophysiology Laboratories, Philadelphia College of Osteopathic Medicine, Philadelphia, Pennsylvania — **"Introduction to Evoked Potential Recording Techniques"**

Maurice Rappaport, M.D., Academic Research Administrator, Brain Function Study Unit, Agnew State Hospital, San Jose, California — **"Evoked Potential Abnormalities in Head Injury — Relative to Disability and Clinical Outcome"**

PANEL DISCUSSION: "Clinical Use of Evoked Potentials" — Drs. Cracco, Gerson, Rappaport.

ADVANCED REGISTRATION

Name _____

Address _____ Telephone _____

City _____ State _____ Zip _____

AMEEGA Member _____ \$150.00 Nonmembers _____ \$190.00 — For entire course including luncheon and banquet.

Please make check payable to: American Medical EEG Association

Send registration to: James G. T. Nealls, M.D., Program Chairman, c/o American Medical EEG Association, 850 Elm Grove Road, Elm Grove, Wisconsin 53122



Two convenient dosage forms:
100 mg (white) and 300 mg (peach)
Scored Tablets



Tablets imprinted with brand name to
assist in tablet identification.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

The NME "establish your practice" benefits package:

- * Over 60 well equipped acute care hospitals.
- * Selected financial assistance.
- * Management consulting.
- * An array of professional service skills and talents to assist you.
- * Locations from coast to coast.

If you're a Primary Care Physician, call for yours today.

For further information, contact:
Raymond C. Pruitt, Director Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.
Call Toll-Free 800-421-7470
or collect (213) 479-5526.

**NATIONAL MEDICAL
ENTERPRISES, INC.**



"The Total Health Care Company."
An Equal Opportunity Employer M/F

CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age. Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

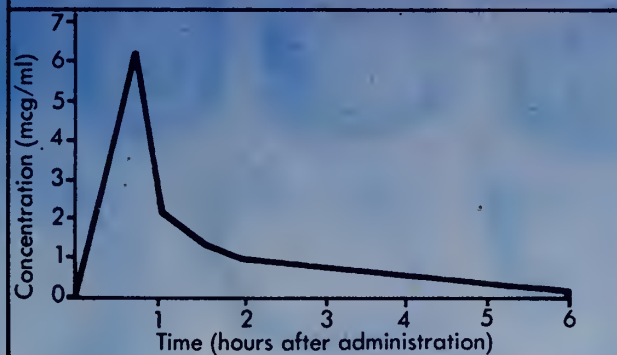
†depending on severity

Wyeth Laboratories
Philadelphia, Pa. 19101

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on $T^{1/2}$ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

Wyeth Laboratories • Philadelphia, Pa 19101



NEW
NAME

PHYSICIAN - REPORTERS



sign up now for the HEALTH REPORTING/ RADIO-TV CONFERENCE

Office of Public Relations, AMA

October 29-31, 1981, Dallas/Ft. Worth Hyatt

You will want to attend if you're a physician already on the air or if you want to break into radio and TV as a health reporter or commentator.

The conference will feature television and radio producers, writers, lay medical reporters and physician reporters. **The program will place special emphasis on small and medium markets.**

The Workshops will cover:

TECHNIQUE (for all market sizes):
Production • Reporting • Interviewing • Critique • Writing • Technology

RESPONSIBILITY: As a reporter to the public • As a physician to the medical profession • legal liability

ANY QUESTIONS YOU BRING WITH YOU

CABLE TELEVISION — A special session

Art Ulene, MD, of the Today Show and Dennis S. O'Leary, MD will be special guests.

The HEALTH REPORTING/RADIO-TV CONFERENCE is an excellent forum to meet other physicians like yourself who are on the air or who want to be.

AGENDA:

Thursday, October 29, 1981

Reception
6:00 - 8:00 p.m.

Friday, October 30, 1981

General Session — Luncheon — Workshops

8:00 a.m. - 5:00 p.m.

Saturday, October 31, 1981

Workshops — Luncheon
8:00 a.m. - 5:00 p.m.

HEALTH REPORTING/RADIO-TV CONFERENCE

Registration: \$125.00, AMA members; \$175.00, non-members. Fee includes reception, all meals and workshops.

Enclosed please find my check for \$ _____, payable to the American Medical Association, 535 N. Dearborn, Chicago, 60610.

☐ I will ☐ I will not attend the reception on October 29, 6:00 — 8:00 p.m.

Please Print:

Name _____

Address _____

City _____

State _____ Zip _____

Phone Number () _____

FOR MORE INFORMATION, CALL COLLECT (312) 751-6614.



Medicine's Spinoffs Alone Justify Space Program

We've heard all the pros and cons about the taxpayers' dollar budgeted for the space program, right?

We've been pelted with verbiage over how that money could have been better used for the impoverished, right?

However, if you would debit the entire cost of the space program against medical research — nobody ever has — you would find the utility value far in excess of the investment. Yes, medicine spinoffs from the space program have saved more lives on a dollar for dollar basis than almost any other past medical research program that any of us might remember. You can compare the efforts of Pierre and Marie Curie, Banting and Best, Salk and Sabin, and even the "Smith Brothers", if that be your choice.

If this subject was researched in great detail, you could easily reveal many isolated discoveries where medicine has benefited as a result of our space program. However, in an effort to emphasize those effects, I have selected one specific area to discuss where space travel really made a difference in the delivery of health care.

Just 15 to 20 years ago, special nurses attending the critically ill around the clock were commonplace. Today, these nurses have been relocated in ICU's and CCU's, monitoring patients, thus enabling optimum care and saving many more lives because of the early diagnoses and prompt treatment of ventricular fibrillation. This simple electronic technique was duplicated from a system originally used on earth, to monitor the astronauts in space. If you think about it for a moment, all we as physicians had to do was to go across the room and hook the patient up to a bedside oscilloscope. And yet, we needed the impetus from space travel engineers to show us physicians the technological know-how.

Prior to the advent of Coronary Care Units, according to Meltzer et al, 30-35% of all patients admitted to hospitals died during the period of hospitalization. With approximately 800,000 patients suffering myocardial infarctions admitted to hospitals each year, this transposes into more than 250,000 dying in the hospital set-

ting. It has been estimated that 50% of those deaths were a result of ventricular fibrillation as a complication of the myocardial infarction. One can then safely prognosticate that this new system saves about 100,000 lives per year. This aims at the very heart of the coronary care concept — that arrhythmic deaths were preventable. Multiply that figure by 15 years and you obtain an idea of what medicine, with the help of Mercury, Gemini and Apollo, has accomplished in this one area. This truly represents the first time an engineer and a medical doctor were forced to work together as a team to find solutions. They did it, and we have benefited!!!

However, at least half of all deaths attributable to myocardial infarction occur prior to the patient reaching the hospital, either during the attack, prior to being seen by a physician or en route to the hospital. This complex problem cannot be solved by the existing system of intensive care. Besides having mobile units which now provide care from the moment that the patient is reached, listen to what's coming!

A cardinal rule of spacecraft design is that everything destined for orbit must be super-efficient, yet as small and as light as technology permits. The latest from miniaturized space circuitry is a tiny patient heart-assist device, implanted like a pacemaker, that could annually prevent thousands of deaths caused by ventricular fibrillation.

The "AID" implantable automatic pulse generator, monitors the heart continuously, recognizes the onset of ventricular fibrillation, and then delivers a corrective electric shock. The AID Pulse Generator is, in effect, a miniaturized version of the defibrillator, but it has the unique advantage of being permanently available to the patient at risk.

We are now finding that the future holds still more sophisticated devices, among the many spinoffs from the space program.

Another development, scheduled for first human implant this year is a microminiaturized, computer-directed system for continuous delivery of medication to

target organs, in precisely controlled amounts, from a source within the patient's body. One important application is in the treatment of diabetes. This Programmable Implantable Medication System serving as an electronic artificial pancreas, could provide further benefit in better control of the body's blood sugar level. Although insulin delivery is the most immediate application, similar advantages in treatment of other diseases where long term injection from an internal source seems indicated. Examples include programmed metering of anti-coagulants, chemotherapeutic drugs, methadone, antabuse or opiates.

In South Miami, Dr. Samuel Berkowitz is conducting research in an inconspicuous but important area of medicine. An orthodontist who also has a degree in anatomy, Dr. Berkowitz has worked on more than a thousand cases involving defects of the head and face, especially the cleft palate. NASA developed an optical profilometer capable of obtaining three-dimensional photos of Mars, showing the height or depth of a planetary feature as well as its length and width. The three-dimensional capability was exactly what was needed for precise palate cast measurement, but further development was required to convert the profilometer to a medical research tool. With guidance from Dr. Berkowitz and three University of Miami assistants, Langley Research Center undertook the modification. Dr. Berkowitz now believes that the precise electronic profiling method of measuring casts will eventually replace the subjective observations now being made by surgeons.

These examples are representative of spinoff innovations in the field of health and medicine extended to

you, me, and our patients, by space technology. Living in the shadow of Cape Kennedy has afforded me the opportunity to watch the analytical mind of many engineers as they complete their work in a most exacting science composed of computers and other sophisticated instruments. Not only has their expertise exposed the not-so-exact science of medicine; but it has forced the engineers to back off, meet the physician scientist halfway, and together solve many common problems, which were necessary for safe and successful travel in space. In the end, the coordinated efforts of space scientists and medical scientists have proved quite beneficial to all our citizens.

Historically, by comparison, Columbus faced many of the same arguments — providing for the poor, tax dollars wasted — when he approached Queen Isabella about seeking the New World, and what eventually would become the home of the first space center. Actually, medical science didn't fare so well on that exploration. Known as the gift of the Spanish conquistadors, Columbus' men brought syphilis to the European continent, and this disease was to ravage the eastern hemisphere for centuries to come.

The next time you watch a liftoff on television, visit the Cape Kennedy Space Center, or even consider the use of taxpayers' dollars, think about the dividends medicine is receiving. Even if we were to debit the entire space effort to medical research alone, the benefits spilling over to us are much greater than the investment per se.

*Joseph C. Von Thron, M.D.
Cocoa Beach*





Professional Liability Legal Update

Informed Consent — Prescription of Drugs

A patient filed a complaint against several manufacturers of prescription steroid drugs seeking damages for bodily injuries resulting from alleged defective products. The patient, in her complaint, alleged that various doctors had prescribed corticosteroids for eye disorders without warning her of known dangerous side effects; that she took the drugs without knowledge of their danger and that as a result she developed aseptic necrosis of her femoral heads which was one of the known harmful side effects. Additionally, it was alleged that the defendant manufacturers knew of the numerous dangerous effects of such drugs and gave adequate warning to the medical profession, but also knew or should have known that the medical profession was not adequately relaying those warnings to the consuming public. The complaint was dismissed for failure to state a cause of action and an appeal was taken from that dismissal.

On appeal, the patient argued that the law requires the manufacturer of an inherently dangerous product to convey a fair and adequate warning of its dangerous potentiality to the ultimate consumer. The court recognized that a manufacturer of a dangerous commodity, such as a drug, does have a duty to warn but felt that when the commodity is a prescription drug the duty to warn is fulfilled by giving adequate warning to those members of the medical community who are fully authorized to prescribe, dispense and administer prescription drugs. Although there have been no previous Florida decisions dealing with this issue, the court agreed with the rationale of the Supreme Court of Washington in a similar case when it stated that where a product is available only by prescription or through the services of a physician, the physician acts as a "learned intermediary" between the manufacturer or seller and the patient. It is his duty to

inform himself of the qualities and characteristics of these products which he prescribes for or administers to, his patients and to exercise an independent judgement, taking into account knowledge of the patient as well as the product. The patient is expected to and, it can be presumed, does place primary reliance upon that judgement. The physician decides what facts should be told to the patient. Thus, if the product is properly labeled and carries the necessary instructions and warnings to fully apprise the physician of the proper procedures for use and the dangers involved, the manufacturer may reasonably assume that the physician will exercise the informed judgement thereby gained in conjunction with his own independent learning, in the best interest of the patient.

The patient further argued that the general rule should not apply to this case because of the additional allegation that the manufacturers knew or should have known that the medical profession was not warning patients of potential side effects. However, the court pointed out that a doctor's duty is to inform his patient what a reasonably prudent medical specialist would tell a person of ordinary understanding of the serious risks and the possibility of serious harm which may occur from a supposed course of therapy so that the patient's choice will be an intelligent one, based upon sufficient knowledge to enable him to balance the possible risks against the possible benefits. The extent of disclosure is a matter of medical judgement. Therefore, the court concluded the doctor's duty to warn patients of possible side effects is not absolute. Since physicians do not have an absolute duty to inform patients of all possible side effects in every instance, failure to do so in a particular instance should not give rise to a duty in the manufacturer. Thus, the trial court's dismissal of the complaint was affirmed.

In arriving at this conclusion, this Florida Appellate Court joined other states in establishing the rule that the duty of a manufacturer to warn of dangers involved in use of a product is satisfied if adequate warning is given to the physicians who prescribe it.

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.



An apple a day won't keep alcoholism away!

The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

Do you have a patient who needs this kind of help? You probably do because the illness is sneaky. For more information and guidelines on how to identify these patients, write to us.

Willingway Hospital

311 JONES MILL ROAD
STATESBORO, GA. 30458

(912) 764-6236

J.C.A.H. ACCREDITED

Choose a practice you can live with.

Hospital Corporation of America knows of many practice opportunities in communities across the nation where we can match a physician's professional needs and personal desires with an attractive community that needs his or her skill.

HCA owns and manages more than 150 hospitals from coast to coast in settings ranging from small, rural towns to large metropolitan centers. Practice opportunities are available in solo, groups, associations, and partnerships.

And HCA will help ease the way when you and your practice relocate. Upon

arrival, you should find a solid practice, conveniently located offices, and the medical support and modern equipment you need.

Contact HCA today. Let our free, no obligation Professional Relations Program match your needs with an HCA practice opportunity. Just send your curriculum vitae, along with information on your personal, professional, and geographical interests to:

Charles M. Wooden, Director, Professional Relations, Hospital Corporation of America, One Park Plaza, Nashville, TN 37203. Telephone toll free 1-800-251-2561 or call collect (615) 327-9551.

HCA Hospital Corporation
of America

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

OCTOBER 1981
VOL 68 • NO. 10

Aerospace Medicine, Central Florida, 1981

Paul Buchanan, M.D.

Abstract: The challenges of Aerospace Medicine are examined from an historical perspective, and an assessment of future goals and responsibilities are discussed.

The territorial prerogative of Aerospace Medicine is a broad one. Beginning with the charge to protect man in flight above and beyond the Earth, and to assure his health on return, it extends to research involving man, lower animals and plants in every imaginable extraterrestrial environment. Also, the terrestrial workplace must be a healthy one so that "Space Base Earth" and its workers are not fouled as work in manned space-flight progresses. In the subspecialty of Space Medicine Operations, perhaps no single area on Earth has had the opportunity to witness the rate and scope of growth as has occurred at the Kennedy Space Center (KSC) since the reusable Space Transportation System, the Shuttle, became an official programmatic goal. For, indeed, the first Space Base Earth is located in Central Florida.

Between 1972 and 1974, in the closing days of the Apollo and Skylab programs, it became obvious that the medical operations support plans used in those programs would not be applicable to a Space Transportation System (STS) with planned launches and landings at KSC 30 to 40 times per year. It was also obvious to some that the rather arbitrary line dividing "Flight Medicine" from Occupation Medicine must be carefully reexamined in anticipation of the ongoing operational milieu and multiple crew positions imposed by the Shuttle/Spacelab planning. The Payload Specialist's involvement with

assigned payloads would, alone, dictate a longer, more demanding job of the crews whose presence was required at the launch and landing site. This factor coupled with the more frequent coming and going of the front cockpit crew (Commander, Pilot, and Mission Specialist) meant that a Flight Medicine Facility capable of maintaining the format, methods and quality of the Astronaut Health Care Program would have to be in place and operational by the time the Shuttle was operational. The frequency of missions, the number and variety of payloads and the international involvement signaled the pending end of the heavy temporary duty assignments (TDY) and the "Traveling Black Trunk Society" from the Johnson Space Center (JSC), which had been part of the regular Astronaut support plan in the Apollo days.

A total reassessment of Medical Operations for the STS era was undertaken by the KSC management. As the Shuttle hardware and its mission planning matured, planning evolved to compliment it. By the late 1970s, the scope of Aerospace Medicine at the prime launch and landing site had been reasonably defined. As the first Shuttle launch approached five key areas of interest and responsibility were identified and assigned to the Kennedy Space Center Biomedical Office. While in reality there is an acknowledge interdigitation of a high degree, for management — and discussion purposes — they are more easily dealt with separately.

The Author

PAUL BUCHANAN, M.D.

Dr. Buchanan is Director, Biomedical Office, NASA, Kennedy Space Center.

Occupational Medicine

It has long been accepted that in an intensive Aerospace setting such as exists at JSC and KSC the two

specialties of Aerospace and Occupational Medicine become virtually indistinguishable. KSC had established a contractor-operated Occupational Medicine Facility in 1964. At that time its primary function was to support the growing Apollo site development and construction activities and the ongoing Gemini launch preparations. As the Apollo Spacecraft and Saturn launch vehicles began to arrive at the north Merritt Island site, needs for a more specialized Aerospace orientation were realized. At the present time, the Project Medical Director is an Aerospace Medical Specialist and two of the clinical staff of seven are similarly trained and qualified. The balance of the staff is composed of internists, generalists and those with advanced Occupational Medicine training. With a support staff of nurses, emergency medical technicians and laboratory technicians a full range of occupational, emergency and incidental medical services are provided daily to the over 14,000 people working at KSC on a 24-hour basis. Special job qualification examinations and employment history reviews demand the greatest share of available professional time. We must assure that the combined civil service and contractor work force is healthy and physically qualified to perform their assigned tasks. This and flight operations support are first priorities.

Treatment and screening for job-related illnesses and injuries and, of course, first aid treatments are also provided in our three Occupational Medical facilities. Since a minimum of 20 miles separates the KSC employee from private medical care, we make every effort to accommodate written requests from practitioners for routine repeated treatments such as certain types of physical therapy and allergy desensitization.

Emergency Medical Support

With the increasing frequency of launch critical activities, the call for "emergency medical services on standby" is in constant contention as the prime levy against our available resources. The minimum standby or response unit is an "ALPHA Team" composed of two EMT-II's (or one EMT-II and a nurse, depending on the nature of the situation) plus a driver/corpsman in a modular ambulance from our fleet of six. The next level of support is a "BRAVO Team" which adds a physician to the unit.

The periodic renewal of training in advanced cardiac life support (ACLS) is a requirement for our physicians. Two of our physicians are certified in advanced trauma life support (ATLS) and more will follow.

Recognized are the facts that limited justification, for extensive trauma care beyond that required for stabilization and transport, must nevertheless, be covered for both daily Center activities and periods of high potential

such as launches and landings. The approach to this problem was trident in nature. First a working agreement was established with the nearest hospital having a 24-hour physician staffed emergency care department — and a Helicopter Landing Facility. This hospital would be designated as the Intermediate Medical Care Facility (IMCF). Jess Parrish Memorial Hospital in Titusville was the most immediate possibility and we were fortunate to be able to establish such a relationship with the Board of that Institution.

The second thrust was for a Definitive Medical Care Facility (DMCF). Requisite elements baselined for such a facility were: (1) A large fully equipped emergency department capable of handling six or more cases at a time, all with extensive trauma. (2) Emergency room capability for toxic substance decontamination. (3) A recognized, full-time, fully staffed Burn Treatment Center. (4) A full-time or immediately available professional staff on which all major specialties are represented. (5) Fully equipped surgeries, ICU and ancillary facilities which would meet the requirements for a major Trauma Care Center. (6) A Hyperbaric Treatment Facility with full staff and equipment capable of handling more than one patient at a time. (7) A governing board and Public Relations Department interested in and willing to work with NASA in this endeavor. (8) All of the above with a lighted helo pad and not more than 100 nautical miles from KSC. Shands Hospital at the University of Florida met all of these requirements. The governing board and staff actively and aggressively assisted in the pursuit of the necessary bureaucratic documentation to make the plan a recognized reality.

The third limb of approach was to obtain a dedicated medical evacuation helicopter for standby at any designated point during periods of critically important activity, or those having the greatest potential for hazard, and to provide rapid evacuation of the injured KSC worker or flightcrew. A standard Army UH-1B already in the NASA inventory was selected for this assignment and outfitted with a special medical equipment station and attachments not only for the three regulation military stretchers but for Gurney and Stokes type litters as well. An oxygen system and medical regulator have also been installed.

During the early Shuttle flights, or Operational Flight Tests (OFT), emergency rescue and evacuation of the crew will be the responsibility of the Air Force, acting under a plan developed by JSC and KSC. The scope of this plan with the magnitude of assigned personnel and aircraft is designed to cover any foreseeable launch and landing contingency occurring in the 140,000 acres of palmetto shrub and wetlands surrounding the launch pads and landing facility. During these operations, consultants representing many medical and dental specialties are on call or are standing by at the Center. Evaluating

this full Apollo-style approach, it is hoped that it can be scaled back to a more economical, multiple use force of "medics" and medium-sized helicopters when full STS operations begin.

Environmental Health

Monitoring the workplace for biochemical toxins and radiological hazards is a responsibility KSC has accepted since the beginning of its operations on Merritt Island. While there was only one major additive change, a fully documented Non-ionizing Radiation Program covering microwave and RF radiation, it was necessary to increase the Industrial Hygiene staff and place an increased emphasis on both the physician interface in toxicological evaluations and the scope and quality of laboratory analysis of environmental samples. The frequency of three shift/seven-day operations and the potential for many new and exotic materials being introduced by the Spacelab payload activities presents the need for a dynamic program that has not yet achieved its final form.

A related but somewhat unique program was added to the Biomedical Office responsibilities with the assignment of the Booster Exhaust Study Tests (BEST) Program for field monitoring activities. New, larger solid rocket motors made it imperative to compare atmospheric and rain data between pre- and post-launch years and to assess the effect of the STS Program on the ecology of natural areas of the Center. More will be written on this interesting effort as further data are collected and analyzed.

Flight Medicine

As stated previously, many factors of the mature STS operations present a clear mandate for a full-scale Flight Medicine Unit at KSC. The physical nucleus of this unit is an eight-room clinical area with X-ray and laboratory left from the days of JSC occupation of the Operations and Checkout (O&C) Building. Following the last Skylab launch, the laboratory was stripped and that equipment, along with most of the examining room equipment, was sent back to JSC. Beginning in 1975, enough of these elements were restored to permit the conduct of FAA aircraft crew examinations and to support the special examinations given prior to the exercise stress tests which were to become a regular part of the health maintenance study covering management and supervisory personnel. In 1978, the Director for Life Sciences, NASA Headquarters, recognized both the need for a

spaceflight crew support capability at KSC and also for certain operationally-oriented research efforts. This resulted in a modest incremental funding program that has provided the facilities and personnel appropriate to the tasks.

Operational Research and Physiological Stress Laboratory

Compared to the projected STS flight model, the temporal demands for preparation and launch of Apollo flight hardware were undemanding. Early in the evaluation of the overall program, two questions repeatedly challenged the staff: (1) Was the personnel protective equipment physiologically adequate and operationally optimal for the projected tasks? (2) Was the true nature and extent of the physiological demands placed upon critical personnel in potentially hazardous, but protected, activities, clearly understood? The Shuttle Program Management was informed that the answer to the second question was "no" and that the first could not be adequately addressed until the second was answered, the Biomedical Office was assigned the task of leading the effort to find the answers. The Health Maintenance/Physiological Stress Laboratory was the center of this activity. Efforts in "the physiological cost of doing work" have been additively directed into special questions of female biochemistry in response to the demands of heavy, prolonged physical efforts and toward the challenges presented by the need to support long duration missions both here and in space.

Conclusion

The Shuttle Program, the STS, should not be viewed as an end in itself. The Shuttle is a cargo carrier; the Spacelab, a temporary orbiting laboratory to study questions of long duration space habitation. The Shuttle and its derivative heavy lift vehicle will place into orbit the materials for the construction of permanent habitable structures. Definition studies for a Space Operations Center (SOC) and a Low Earth Orbiting Station (LEOS) are well along. In their construction, operation and maintenance, Kennedy Space Center will be the "hub," truly Space Base Earth. As this occurs, Space Medicine — here in Central Florida — must progress to meet the challenges. This is the next step.

- Dr. Buchanan, M.D., John F. Kennedy Space Center, NASA, Kennedy Space Center 32899.

A Case of Shellfish Associated Cholera in South Florida

G. E. Rodrick, Ph.D., M. Lotz, M.D., N. G. Alexiou, M.D. and J. Ambrusko, M.D.

Abstract: Gastroenteritis caused by cholera organisms increasingly presents a diagnostic problem in Florida. There is increasing evidence that *Vibrios*, similar to *Vibrio cholerae*, but which do not agglutinate with *Vibrio cholerae* (0-group 1) antisera, have caused several cases of acute gastroenteritis in Florida. This report presents an outbreak of oyster-associated gastroenteritis due to these organisms in Bradenton, Florida. Four persons were made ill, one of whom required hospitalization after eating raw oyster harvested from a prohibited shellfish area in Palma Sola Bay, Bradenton, Florida on December 16, 1979. Non-agglutinating 0-group 1 *V. cholerae* was isolated from both the feces of the hospitalized patient and the shellfish-associated water.

Introduction

In recent years there has been increasing evidence suggesting that the non 0 group 1 *Vibrio cholerae* (NAGs) may be pathogenic for man and a cause of human intestinal infections.^{1 2 3 4}

These studies usually involved the investigation of sporadic cases of a cholera-like disease occurring in areas where cholera is known to be endemic. Few reports of a food-poisoning type of illness due to non-agglutinating, non-toxic *Vibrio cholera* has been reported in detail; previously, none have been reported for Florida.

This paper describes an outbreak of shellfish poisoning which occurred in Bradenton, Florida. Non-agglutinable vibrios were isolated in large numbers from the patient and biochemically identified as *Vibrio cholerae*. Outbreaks of similar cholera-like food poisoning have occurred in other regions of Florida with increasing frequency. Such sporadic outbreaks offer the opportunity

for epidemiological study which may contribute to improved environmental conditions as well as prompt diagnosis and treatment.

Materials and Methods

Report and Epidemiological Survey. Patient and two friends ingested oysters harvested from Palma Sola Bay on December 16, 1979. The patient, his son, and two friends developed diarrhea that evening with nausea, vomiting, fever and chills. The son chewed but did not swallow the suspect oyster. Family members were not involved and two friends who had also harvested oysters denied illness. The patient required hospitalization the following week for intravenous support and was discharged three days later fully recovered.

Environmental Investigation. On January 7, 1980, a sample of seawater and oysters were collected from the site at Palma Sola Bay, Florida. Both samples were shipped to the Gulf Coast Technical Services Unit of Federal Food and Drug Administration at Dauphin Island, Alabama. Oysters were examined qualitatively for *Vibrio cholerae* and quantitatively for fecal coliforms and organisms were enumerated by the standard 35°C aerobic plate count procedure. Seawater sample was examined quantitatively for both *V. cholerae* and fecal coliforms organisms.

The oyster sample was negative for *V. cholerae* and yielded a fecal coliform most probable number (MPN) of 20 organisms per 100 grams and a plate count of 4,500 organisms per gram. Both these values are well below the bacterial levels recommended for shucked oysters at the wholesale market level.

The Authors

G.E. RODRICK, Ph.D. AND N.G. ALEXIOU, M.D.

Drs. Rodrick and Alexiou are with the Department of Comprehensive Medicine, University of South Florida College of Medicine, Tampa.

M. LOTZ, M.D.

Dr. Lotz is with the Department of Pathology, University of South Florida College of Medicine.

J. AMBRUSKO, M.D.

Dr. Ambrusko is with the Manatee County Health Department, Bradenton.

In contrast to the oysters, the seawater sample yielded a culture of *V. cholerae* which failed to agglutinate 0-group 1 antiserum. The MPN of *V. cholerae* in the seawater sample was 0.9 organisms per liter. The fecal coliform content of the seawater was 33 organisms per 100 ml.

Laboratory Investigation. Fecal swabs from patient were plated directly on thiosulfate citrate bile salts (TCBS) agar plates. Suspect colonies were transferred to gram-negative (G.M.) broth, and grown on blood agar, eosin-methylene blue agar (E.M.B.), *Salmonella-Shigella* (S.S.) and sucrose lysine desoxycholate (SLD) plates. Suspect colonies contained gram-negative rods. Biochemical analysis and identification was performed using an API-20E biochemical tests (Analytab Products). Suspect colonies were found to be non-toxigenic, non 0-group 1 agglutinating *V. cholera* by the Clinical Laboratory of the Manatee Memorial Hospital. Samples were also sent to the Department of Health and Rehabilitative Services, Office of Laboratory Services for confirmation of identity. Bacteriological examinations confirmed that the suspect colonies were non 0-group 1 agglutinating, Smith type 27, 348 *V. cholerae*. No toxin production was demonstrated. The isolated strain of cholerae was found to be resistant lincomycin, carbenicillin and clindomycin, and sensitive to penicillin, erythromycin, cefamandole, ampicillin, cephalothin, chloramphenicol, tetracycline, tobramycin, colistmethate, gentamycin, nitrofurantoin, kanamycin, amikacin sulfate and trimethoprim sulfamethoxazole. The patient was treated with I.V. fluids and tetracycline during a 48 hour period and released. Rectal swab cultures of the patient were negative at the time of release.

Discussion

The outbreak of shellfish poisoning described in this paper adds further evidence that certain non-agglutinating *Vibrio cholerae* can be pathogenic to man. Only one serotype of vibrio species was isolated from the fecal samples.

These halophilic NAG-*Vibrios* are common in Florida coastal waters and marine products.^{4,5} In addition, they have been detected in several different species of edible shellfish collected in approved shellfish harvesting water in Florida waters.⁵

During the past eighteen months, the Department of Comprehensive Medicine, at the University of South Florida College of Medicine, has investigated several other incidents of shellfish-associated cases of gastroenteritis in Florida. These outbreaks indicate that non-agglutinating 0-group 1 *V. cholerae* do play an important role in diarrheal illness associated with the consumption of raw and/or improperly cooked shellfish.

Patients presenting with diarrhea may have acquired their illness from a non 0-group 1 *Vibrio cholerae* associated with raw seafood from a wide range of waters. Although, this illness may be seen more frequently in coastal areas, it could occur inland as well.

The clinical feature of gastrointestinal illness caused by non 0-group 1 *V. cholerae* cannot be described with any confidence.³ However, bloody diarrhea along with frequent cramps, pain, loose watery diarrhea, fever not usually found in classic cholera, has been a common occurrence in the cases in Florida.³

The physician can contribute to the epidemiologic surveillance by suspecting cholera in patients with diarrheal disease who have a history of ingesting raw or poorly cooked shellfish especially from harvesting areas which are unapproved or prohibited.

A possible contact with contaminated seafood or water elicited by history should suggest appropriate laboratory studies, specifically including a stool examination for *Vibrio* organisms.

The clinical pathologist should culture the specimen in alkaline peptone enriched water for 6-8 hours to amplify their low numbers of *Vibrio* organisms.

Thiosulfate citrate bile salts (TCBS) agar should be used as the culturing medium for all diarrheal stools because of its specificity and sensitivity. While false positives may occur (yellow colonies which are not *Vibrio*), almost all *Vibrio* species will grow well.⁶ *V. cholerae* is usually easily overlooked by standard analytical methods for common enteric bacterial pathogens.

In addition, analytical procedures outlined in "Recommended Procedures for the Examination of Seawater and Shellfish"¹ are recommended for examining food products and environmental samples.

Until recently, non-agglutinating *Vibrio cholerae* has not been considered a public health threat. Although, classic and El Tor cholera epidemics are usually associated with sewage-contaminated water and food, the non 0-group 1 *V. cholerae* isolated appear to be ubiquitous in environmental waters.

Currently, we are conducting studies of the incidence of *V. cholerae* in both Florida waters and oysters. Non 0-group 1 *V. cholerae* has been found over a wide geographic range of coastal waters. Several 0-group 1 isolates have been found. However, no toxins have been identified by any of these isolates to account for their disease producing characteristics.

Acknowledgements

We wish to thank both the Manatee County Health Department and the Manatee Memorial Hospital's clinical laboratory for their help and assistance. This research was supported in part by Florida Sea Grant No. 125 720073/257*V73.

References

1. American Public Health Association. 1976. A.P.H.A. Recommended Procedure for the Examination of Seawater and Shellfish, New York.
2. Blake, P.A.; M.L. Rosenberg; J. Bandeira Costa; P. Soares Ferreira; C. Levy Guimaraes and E.J. Gangarosa. 1977. *Am. J. Epidemiol.*, 105:337-343.
3. Blake, P.A.: 1981 *Ann. Rev. Microbiol.*, 34:341-367.
4. Hood, M.A.; Ness, G. and Rodrick, G.E.: 1981 *Appl. Environ. Microbiol.*, 41:559-560.
5. Tamplin, M.; McKnight, C.; Rodrick, G.E. and Blake, N.: 1981 81st Ann. Amer. Soc. Microbiol., (Abstr.) pp. 212.
6. Lotz, M.J.; Tamplin, M.; Alexiou, N. and Rodrick, G.E.: 1981 *Ann. Clin. Lab. Sci.* (In Press)

● Dr. Rodrick, Box 12, 12901 North 30th Street, Tampa 33612.

17 Florida Hospitals Scheduled for JCAH Review

The Joint Commission on Accreditation of Hospitals announced that 17 Florida hospitals were scheduled for surveys for the fourth quarter of 1981 (October through December).

They are: Calhoun General Hospital, Blountstown; Washington County Hospital, Chipley; Okaloosa Memorial Hospital, Crestview; Morton F. Plant Hospital, Clearwater; U.S. Air Force Hospital, Eglin Air Force Base; North Florida Regional Hospital, Gainesville; St.

Luke's Hospital, Jacksonville; and Community Hospital, New Port Richey.

Marion Community Hospital, Ocala; Gadsden Memorial Hospital, Quincy; Sacred Heart Hospital, Baptist Hospital and Naval Aerospace and Regional Medical Center, all of Pensacola; Bay Memorial Medical Center and Gulf Coast Community Hospital, both of Panama City; Memorial Hospital, Williston; and Greater Orange Park Community Hospital, Orange Park.

Lithium

Overview of Practical Considerations

Carlos E. Muniz, M.D., Louis J. Perillo, M.D.
Anthony G. Troiano, M.D., and Mark H. Binus, M.S., R.Ph.

Abstract: Lithium use has increased dramatically over the past several years but the overall picture of its specific indications, side effects, and available preparations may not be clear. This overview is intended as a quick reference for practitioners, along with basic suggestions for management of patients on lithium.

Lithium carbonate has been used in this country since 1970, when the FDA approved it for the treatment of mania. Later, it was also approved for prophylaxis against the manic and depressive episodes characteristic of the bipolar affective disorders. Presently its use in the treatment of numerous other psychiatric conditions is under investigation, such as depression, alcoholism, pathological aggression, and certain types of schizophrenia. It has also been tried experimentally in certain medical conditions such as granulocytopenia and cluster headaches. At the same time, new or previously unrecognized toxic manifestations are being discovered, making it more difficult for the clinician to decide when to use lithium, and if so, for how long. Among these previously unrecognized toxic manifestations, one has occupied the limelight in the past three years because of its potential seriousness — the possible nephrotoxic effect.

Lithium Preparations

Lithium is available for oral use in tablet, capsule, and syrup forms. There are only two lithium salts cur-

rently available in the United States, the carbonate and the citrate. The citrate salt is marketed in a liquid dosage form, and the carbonate salt is marketed in both tablet and capsule forms. Table 1 lists the nine products commercially available, with trade name, manufacturer, and dosage form.

A recently published comparison of seven lithium carbonate products found no significant bioavailability differences.¹ Bioavailability data provided by Rowell laboratories, a producer of lithium, suggest that their liquid form of lithium, Lithonate-S, is bioequivalent to both the tablet and capsule forms. It appears that practitioners can safely use any of the currently available lithium products and be assured of bioequivalence. However, one must keep in mind that there may be slight differences in the nine products listed as to dissolution and absorption rate (due to binders, disintegrators, and other excipients), and patients maintained on one brand should remain on that brand. If it becomes necessary to switch to another brand, careful monitoring of lithium blood levels and close observation of the patient will alleviate potential problems.

The Authors

CARLOS E. MUNIZ, M.D.

Dr. Muniz is Associate Professor of Psychiatry, University of Florida College of Medicine, Gainesville.

LOUIS J. PERILLO, M.D., ANTHONY G. TROIANO, M.D.

Drs. Perillo and Troiano are Residents in Psychiatry at the University of Florida.

MARK H. BINUS, M.S., R.Ph.

Mr. Binus is a Pharmacy Resident at the University of Florida.

Clinical Indications

Psychiatric Disorders

A. Bipolar Affective Disorders

We have to distinguish between treatment during a manic episode, a depressive episode, and the symptom-free intervals. Lithium has been demonstrated to be an effective agent in the treatment of manic episodes, regardless of their etiology. Because neuroleptics are also useful antimanic agents, the decision has to be made as

to which drug regimen to use, lithium, a neuroleptic or a combination of both. Most clinicians agree that in severe psychotic manic episodes requiring energetic treatment neuroleptics are the drugs of choice because of their rapid onset of action as compared to lithium, which usually takes about seven days before a therapeutic drug level is reached. If, on the contrary, the patient has a hypomanic episode, then lithium is the drug of choice, as it has a smoother antimanic effect without the possible extra-pyramidal and anticholinergic side effects of the neuroleptics. A combination of neuroleptics and lithium can be used safely, although there have been isolated reports of increased neurotoxicity with the combinations of lithium and haloperidol,² and lithium plus thioridazine.³

In bipolar depression, a tricyclic antidepressant may be used in conjunction with lithium, if there is no response to lithium alone. The lithium can help prevent a hypomanic response to the antidepressant.⁴

During the symptom-free intervals lithium has been shown to be an effective prophylactic drug in approximately 60% of patients. We still do not have clear-cut predictors of positive response, but patients who have less than four affective cycles per year (a.k.a. slow cyclers), and presence of the illness in first degree relatives, seem to respond better. One unresolved issue at this point is the blood level necessary for prophylactic purposes, since the level of 0.8 to 1.2 mEq per liter suggested by Shou for the treatment of the manic episodes may be unnecessarily high. This is an important issue, since nephrotoxicity could very well be related to high serum levels.

B. Schizophrenia

Lithium's place in the treatment of schizophrenia is still uncertain. Although some studies have shown lithium to be ineffective when it is given alone in schizophrenia, recent research has indicated a potential antipsychotic effect.^{5,6} These studies have suggested that using a combination of lithium and neuroleptics for some schizophrenics can produce a reduction in psychotic excitement. This would lend support to the premise that while modifying the activity levels in schizophrenia, it does not affect the primary symptomatology.

In defining the role of lithium in schizophrenia today, it should be noted that although we are seeing the potential of its antipsychotic affects, the treatment of choice continues to be the use of neuroleptics. However, lithium can be utilized in certain situations as an alternative treatment modality. Examples of this would be in individuals who show no response to neuroleptics, or who are adversely effected by their side effects. In certain medical conditons where neuroleptization is contraindicated, lithium may be helpful. Lastly, lithium may be most useful in those schizophrenic patients who demonstrate a pronounced affective component.^{6,7}

C. Others

Lithium has also been used in other psychiatric disorders, although not as yet approved by the FDA. For example, it has been used experimentally with some positive results for pathological aggression,⁸ alcoholism,⁹ and self-mutilating behavior.¹⁰

Table 1. — Available Lithium Preparations.*

Trade Name	Manufacturer	Dosage Form
1. Lithium carbonate†	Philips Roxane	300 mg. caps.
2. Eskalith	SKF	300 mg. caps.
3. Lithonate	Rowell	300 mg. caps.
4. Lithium carbonate	Philips Roxane	300 mg. tabs.
5. Lithane	Dome	300 mg. tabs.
6. Lithotabs	Rowell	300 mg. tabs.
7. Lithobid	Rowell	300 mg. slow release tabs.
8. Lithium citrate‡	Philips Roxane	syrup, 8 mEq Li/5 ml
9. Lithonate — S	Rowell	syrup, 8 mEq Li/5 ml

*Facts and Comparisons, 1980, p. 268 f. Facts and Comparisons, Inc., St. Louis.

†1-7 as carbonate salt.

‡8-9 as citrate salt (usual initial dose is 16 mEq lithium TID; usual maintenance dose is 8 mEq lithium or QID).

Nonpsychiatric Medical Disorders

Lithium carbonate has been used with a certain degree of success in the treatment of several non-psychiatric conditions. Among them, the most promising results have been obtained in the therapy of granulocytopenia¹¹ and cluster headaches.¹² In the former, lithium increases the granulocytic pool without affecting the phagocytic function of the granulocytes. Since the first report that lithium was effective in treating cluster headaches appeared in the literature in 1974, several uncontrolled

studies have raised hopes that lithium might benefit some of these patients.

Drug Interactions

Lithium interacts with many drugs. It is important to keep in mind that although it can be used safely with most drugs, in certain cases monitoring of blood levels becomes even more important since it has such a low therapeutic index. Table 2 lists those interactions that are known to be clinically significant or potentially serious.

Table 2. — Drug Interactions with Lithium^{13,14,15}

Drug	Effect	Comments
Haloperidol	Possible additive effect with increased neurotoxicity	Observe patient closely
Indometacin	Serum lithium levels increased 30-60%	Monitor levels closely
Thiazide Diuretics	Decreased renal lithium clearance, increased lithium levels	Monitor levels closely
Osmotic Diuretics	Increased lithium clearance	Monitor levels
Iodide	May enhance hypothyroid and goitrogenic effects	Get baseline thyroid function tests
Neuromuscular Blocking Agents	Lithium may prolong blockade	Avoid if possible or monitor closely
Sodium Bicarbonate	Increased renal lithium clearance	Monitor levels
Elavil	Generalized convulsions have been reported	Use alternate tricyclic or observe closely

Adverse Effects

Whenever lithium use is indicated, its possible beneficial effects have to be weighed against its possible toxic effects. Several new developments in this area have recently been uncovered.

CNS Toxicity

This does not always present itself with the classic picture of drowsiness, ataxia, tremors, muscle fasciculations, and increased reflexes leading gradually to convulsions, and finally death. There are cases of severe toxicity in which one or two symptoms appear alone. There have been cases reported, for example, in which ataxia, tremor, or confusion has been the only indication of toxicity.

At one time it was thought that toxicity occurred only when serum levels rose to 2 mEq per liter or higher, but now we know that severe cases of neurotoxicity can develop with serum levels as low as 0.9 mEq per liter.¹⁶ Acute confusional episodes have been reported in certain susceptible individuals with very low serum levels. This occurred mainly in older patients with organic brain syndromes.

Cardiovascular

When it first came into use, lithium was not considered cardiotoxic. It has been known for some time that flattening of T waves can and will occur in many cases, but usually has no pathological significance. In the last few years, however, a few cases have been reported for

more serious pathology, such as sinoauricular blockade.¹⁷ It is now recommended to obtain an EKG if a patient on lithium begins complaining of dizziness or vertigo.

Gastrointestinal

Recently, cases of stomatitis and symptoms of upper gastrointestinal irritation such as heartburn have been described with lithium tablets.¹⁸ These subsided shortly after the medication was changed to the capsule form. Other gastrointestinal symptoms such as nausea, abdominal cramps, and loose stools are related to lithium blood level peaks, and can be avoided through the use of slow release dosage forms, giving a lower lithium dose, or by giving the medication in divided doses and with meals.

Dermatologic

Skin manifestations such as acne and follicular hyperkeratosis¹⁹ are seen occasionally. They disappear when lithium is discontinued, and usually do not recur even after lithium is restarted.

Endocrine

It was not until 1968 that the goitrogenic effect of lithium was first discovered. The incidence of goiter in patients treated with lithium is relatively low (0.3% in one study of 2,590 patients)²⁰ and if it occurs the goiter is usually small and goes undetected. Hypothyroidism is another known side effect, the incidence of which varies according to different studies between 4% and 14%.²¹ Both goiter and hypothyroidism are reversible when

lithium is stopped, and it usually takes a period of at least six months of continuous administration for them to develop. When a patient on lithium develops symptoms suggestive of depression, the possibility of myxedema masquerading as such has to be kept in mind. In terms of the mechanism, lithium has been shown to block the effect of TSH on the thyroid gland, to impair coupling of iodothyrosine molecules, and to interfere with the release of hormone from the gland.

A few cases of thyrotoxicosis, difficult to explain, have also been reported, both during lithium therapy and soon after the drug has been discontinued.²² Thyrotoxicosis itself can easily be confused with mania.

Nephrotoxicity

The relationship between lithium and renal toxicity is not entirely clear. The greatest interest has mounted since 1977 when several studies showed the occurrence of interstitial fibrosis, nephron atrophy, and glomerular sclerosis in patients on long term lithium maintenance.²³ Controls showed far fewer changes. The most ominous reports have been those documenting serious, and potentially irreversible, renal damage in patients on lithium who had been shown not to have exhibited renal deficits prior to the initiation of treatment.²⁴ Other studies have shown lithium to have an effect on renal concentrating ability,²⁵ which must be kept in mind when water conservation is a necessity (fever, surgery, etc.). Despite the number of articles attesting to lithium's effects on the kidney, many questions remain to be answered. As Lippmann and Wagemaker have pointed out, we have yet to see a relative increase in renal mortality in patients on lithium, nor have we seen an increased incidence of renal failure in the general population despite the great increase in the use of lithium.²⁶

While these questions are being answered, we must take the proper precautions. Prior to initiating treatment, get baseline renal function test — urinalysis, BUN, creatinine, and electrolytes — and monitor these values at least once a year. One fact to keep in mind is that the kidney's functional reserve is such that BUN and creatinine may not change significantly until considerable damage has occurred. More sensitive indicators are urine volume, specific gravity, and creatinine clearance (measured by a 24 hour urine). Of course, lithium levels should be obtained regularly to avoid toxic levels. In addition, there is some evidence that nephrotoxicity, like

gastrointestinal complications, is related to peaks in serum concentration. These peaks are avoided as previously described.

Summary

In conclusion, lithium is not an innocuous drug to be used in every case in which it is theoretically indicated. It should be used cautiously, and discontinued if the supposed therapeutic effects are not forthcoming, or if toxicity develops. Each patient should be considered individually, and the positive and negative effects carefully assessed.

References

1. Needham, T.E.; Javid, P., and Brown, W.: Bioavailability and Dissolution Parameters of Seven Lithium Carbonate Products, *J. Pharm. Sci.* 68:952-954, 1979.
2. Cohen, W.J. and Cohen, N.H.: LiCo₃, Haloperidol, and Irreversible Brain Damage, *JAMA* 230: 1283-1287, 1974.
3. Spring, G.K.: Neurotoxicity with Combined Use of Lithium and Thioridazine, *J. Clin. Psych.* 40:135-138, 1979.
4. Shopin, B. and Waters, B.: Pharmacotherapy of Major Depressive Syndrome, *Psychosomatics* 21:649-656, 1980.
5. Alexander, P.E.; VanKammen, D.P. and Bunney Jr., W.E.: Antipsychotic Effects of Lithium in Schizophrenia, *Am. J. Psych.* 136:283-287, 1979.
6. Bronkington, I.F., et. al.: Trials of Lithium, Chlorpromazine, and Amitriptyline in Schizoaffective Patients, *Brit. J. Psych.* 133:162-163, 1978.
7. Prien, R.F.; Caffey Jr., E.M. and Klett, C.J.: Comparison of Lithium Carbonate and Chlorpromazine in Treatment of Excited Schizoaffectives, *Arch. Gen. Psych.* 27: (August) 1972.
8. Sheard, M.H.: Lithium in Treatment of Aggression, *J. Ner. Ment. Dis.* 160:108-118, 1975.
9. Kline, M.S.; Wren, J.C.; Cooper, T.B., et. al.: Evaluation of Lithium Therapy in Chronic and Periodic Alcoholism, *Am. J. Med. Sci.* 268:15-22, 1974.
10. Micev, V. and Lynch, D.M.: Effect of Lithium on Disturbed Severely Mentally Retarded Patients, *Brit. J. Psych.* 125:110, 1974.
11. Gupta, R.C., et. al.: Felt's Syndrome, Effect of Lithium on Granulopoiesis, *Am. J. Med.* 61:29-32, 1976.
12. The Medical Letter on Drugs and Therapeutics, Vol. 21, Sept. 21, 1979.
13. Hansten, P.: Drug Interactions. Lea and Febiger, Philadelphia, 1979.
14. Jefferson, J.W. and Greist, J.H.: Lithium Interactions With Other Drugs, unpublished.
15. The Medical Letter on Drugs and Therapeutics, Vol. 22, Feb. 22, 1980.
16. Muniz, C.E.; Forman, A.J.; Wilder, B.J. and Ramsay, R.E.: Lithium Toxicity With Low Serum Levels — Report of Case, *Clinical Electroencephalography* 7:31-34, 1976.
17. Hagman, A., et. al.: Syncope Caused by Lithium Treatment, *Acta. Med. Scand.* 205:467-471, 1979.
18. Muniz, C.E. and Berghman, D.H.: Contact Stomatitis and LiCo₃ Tablets, *Letter in JAMA* 239:2759, 1978.
19. Rifkin, A.; Kurtin, S.B.; Quitkin, F., et. al.: Lithium Induced Folliculitis, *Am. J. Psych.* 130: 1018-1019, 1973.
20. Piziak, V., et. al.: Lithium and Hypothyroidism, *J. Clin. Psych.* 39:703-711, 1978.
21. Mannisto, P.T.: Hypothyroidism During Lithium Treatment, Review of 49 Cases, *Psych. Fenn.* 299:308, 1974.
22. Reus, V.I.; Gold, P. and Post, R.: Lithium Induced Thyrotoxicosis, *AM. J. Psych.* 136:724-725, 1979.
23. Hestbech, J., et. al.: Chronic Renal Lesions Following long Term Treatment With Lithium, *Kidney Int.* 12:205-213, 1977.
24. Neu, C.; Manschreck, T.C., and Flocks, J.M.: Renal Damage Associated With Long Term Use of Lithium Carbonate, *J. Clin. Psych.* 40:460-463, 1979.
25. Vestergaard, P.; Amdisen, A.; Hansen, H.E. and Schou, M.: Lithium Treatment and Kidney Function, A Survey of 237 Patients in Long Term Treatment, *Acta Psychiat. Scand.* 60:504-520, 1979.
26. Lippman, S. and Wagemaker, H.: Lithium — Nephrotoxic Potential, unpublished.

● Dr. Perillo, Department of Psychiatry, JHMC, Gainesville 32610.

Encephalopathy Secondary to Abusive Gasoline Inhalation

Leon D. Prockop, M.D. and Dean Karampelas, M.D.

Abstract: Although the neurotoxicity of inorganic lead is well-known, that associated with inhalation of gasoline containing organic lead, e.g., tetraethyl lead, is not. We report a 19-year-old man who developed diffuse as well as multifocal neurological deficit after abusive inhalation of gasoline containing lead. His deficits included: dementia, nystagmus, dysarthria, truncal ataxia, extremity dysmetria and pathologically increased deep tendon reflexes. Although he improved after EDTA therapy, persisting neurological dysfunction was noted. In this case, the relative contributions of the lead and the volatile hydrocarbons in gasoline in causing a neurological damage could not be determined.

Neurological disorders caused by volatile substances were little known ten years ago, but are now being reported with increasing frequency.¹ Individual compounds and mixtures of compounds, mainly hydrocarbons including the organic solvents, are increasingly being identified as potentially neurotoxic. Neurological syndromes owing to volatile substances occur after both accidental (usually occupational) exposure and deliberate exposure (inhalant abuse).

A young man was admitted to hospital in September, 1979 and again in November, 1980 with delirium and ataxia as well as diffuse and multifocal neurological deficits after inhalation of fumes of leaded gasoline for the pleasant visual hallucinations and fantasies produced.

Case Report

In 1979, a 19-year-old man exhibited delirium and ataxia after prolonged voluntary inhalation of gasoline. Details of the hospital admission which occurred at that time are not available. However, it is known that blood lead levels were initially elevated and became normal after EDTA therapy. Ataxia which had been present on admission improved but with mild residual. Extensive psychiatric evaluation and therapy occurred.

The Authors

LEON D. PROCKOP, M.D.

Dr. Prockop is Professor of Medicine (Neurology), College of Medicine, University of South Florida, Tampa.

DEAN KARAMELAS, M.D.

Dr. Karampelas is a medical resident at the University of South Florida Affiliated Hospitals, Tampa.

In November 1980, he appeared in the emergency room in a state of agitated delirium. On physical examination, the patient appeared to be a well-developed and well-nourished white male. Vital signs were: T. 37°C, respiratory rate 30 per minute, heart rate 120 per minute, and blood pressure 110/60 mm Hg. General physical examination was within normal limits. Because of the patient's delirium and agitation, only a limited neurological evaluation was possible initially.

A complete blood count and urine analysis were normal. The following studies were also normal: calcium, phosphate, BUN, uric acid, SGOT, alkaline phosphatase, sodium, chloride, CO₂, potassium, blood sugar, routine urinalysis and urine porphyrin level. The only abnormalities noted were: a serum lead level of 84 mcg/dl (normal is 0-50); 24h urine lead; 216 mcg/dl (normal is less than 100); SGOT 129 units; and CPK 2874 (all fraction 3).

The delirium cleared within 24 hours such that further historical review was possible. He admitted inhaling fumes of two gallons of leaded gasoline in the preceding month, for the pleasurable visual hallucinations and fantasies produced. Subsequent neurological examination documented: dementia, nystagmus, dysarthria, truncal ataxia, extremity dysmetria, pathologic increased DR's and mild distal sensory impairment.

Subsequent psychometric evaluation documented recent memory impairment. Brain CT scan demonstrated mild prominence of the ventricles and of the cortical sulci. Lumbar puncture was performed under normal pressure with normal findings in the CSF. EEG, nerve conduction velocity and sural nerve biopsy were performed, all with normal findings.

Although blood lead concentration became normal after EDTA therapy, the neurological deficits persisted in a somewhat improved state at the time of discharge 3 weeks after admission. He was lost to follow-up care.

Discussion

The efficiency of the pulmonary absorption of gases and volatile liquids has been known since prehistoric times.² The surface area of the pulmonary epithelium and the mucous membranes of the respiratory tract is large, and absorption is rapid. The advantages of pulmonary

transfer of consciousness-altering substances has been widely exploited. The method of ancient Greeks at Delphi was rather sophisticated. An old woman known as the Pythoness was seated over a vent in a rock from which CO₂ emanated, producing a trancelike state during which the subsequent act of divination occurred. Ether and chloroform have had interesting histories of recreational usage before they came to be mundane anesthetics. One of the earliest descriptions of abusive inhalation of commercial solvents, is that of Clinger and Johnson³ who reported a localized outbreak of gasoline sniffing. Subsequently, articles appeared about model airplane glue sniffing. Eventually a long list of vaporizing liquids came to be abused. These included various contact cements and adhesives, paints, lacquers and their thinners, dry cleaning fluids and spot removers, transmission and brake fluids, nail polish removers, degreasers, refrigerants, and other volatile products.⁴

Although little is known about the specific mechanisms whereby the volatile agents cause neurological syndromes, the neuropathological sequelae of their inhalation have been documented in humans and experimental animals.⁵⁻⁷ The volatile substances involved include aromatic and aliphatic hydrocarbons, alcohols, esters, ketones, aliphatic nitrates, anesthetic agents, halogenated solvents and propellants.

Death after exposure to gasoline fumes is generally attributed to severe cerebral depression, terminating in respiratory paralysis. Frightening hallucinations with chorea and abnormal electroencephalograms, peripheral neuropathy, and ataxia with tremor and dementia have all been reported after gasoline inhalation.⁸ Because gasoline is a mixture, sometimes including lead, it has been difficult to define its neurotoxicity. In our case it is not possible to say whether the neurological deficits and brain CT findings were the result of lead toxicity alone, volatile hydrocarbon toxicity, or a combination of both. The mechanism(s) by which such toxins cause human nervous system damage is not known although the volatile hydrocarbon may facilitate entry of the lead into

brain tissue. In rats, tetraethyl lead is rapidly metabolized and converted to triethyl lead. Administration of either compound produces symptoms that are remarkably similar to those in human acute tetraethyl lead poisoning. By contrast, diethyl lead and lead acetate are relatively inactive.⁹

Although our patient improved with chelating agents, residual neurological deficit occurred. If death is averted with gasoline intoxication, complete recovery is the rule. However, our case illustrates that residual damage may occur. Alpey and co-workers report chronic progressive encephalopathy due to gasoline sniffing.¹⁰ In their case, death eventually occurred. The formalin-fixed brain lead content was between 5200 and 6500 ug per 100 gm of tissue. The most common autopsy finding in other cases of acute organic lead intoxication was congestion of visceral organs, particularly the lungs.

Our case illustrates still another cause of psychiatric and neurological dysfunction of which the clinician must be aware.

References

1. Prockop, L.: Neurotoxic Volatile Substances, *Neurology*. 24:862-865, 1979.
2. Cohen, S.: Inhalant Abuse: An Overview of the Problem, in *Review of Inhalants. Euphoria to Dysfunction*, C.W. Sharp and M.L. Brehm, eds. NIDA Research Monograph 13, Washington, D.C., 1977.
3. Clinger, O. and Johnson, W.: Purposeful Inhalation of Gasoline Vapors, *Psychoanal Q.* 25:557-559, 1951.
4. Sharp, C.W. and Carroll, L.T. (eds): *Voluntary Inhalation of Industrial Solvents*, National Institute on Drug Abuse, Rockville, MD, 1978.
5. Prockop, L.D.; Alt, M. and Tison, J.: Huffer's Neuropathy, *JAMA*. 229:1083-1084, 1974.
6. Mendell, J.; Sauda, K.; Ganansia, D., et al: Toxic Polyneuropathy Produced by Methyl N-butyl Ketone, *Science*. 185:787-9, 1974.
7. Means, E.; Prockop, L. and Hooper, G.: Pathology of Lacquer Thinner Induced Neuropathy, *Ann. Clin. Lab. Sci.* 6:240-50, 1976.
8. Oldham, W.: Deliberate Self-Intoxication With Petrol Vapor, *Br. Med. J.* 2:1687-88, 1961.
9. Cremer, J.E.: Biochemical Studies on the Toxicity of Tetraethyl Lead and Other Organic Lead Compounds, *Br. J. Ind. Med.* 10:191-199, 1959.
10. Valpey, R.; Sumi, S.B.; Copass, M.D. and Goble, G.J.: Acute and Chronic Progressive Encephalopathy Due to Gasoline Sniffing, *Neurology*. 28:507-510, 1978.

- Dr. Prockop, 12901 W. 30th Street, Box 19, Tampa, FL 33612.

Congenital Listeriosis: Case Report

S. C. Huang, M.D.

Congenital listeriosis is a rare, under-diagnosed and under-reported disease with considerable mortality.¹ Since a high index of suspicion on the part of the attending physician and prompt treatment can convert the serious sequelae to complete cure, presentation of a case is pursued as a reminder.

Report of Case

A 24-year-old, gravida 3, para 2, "A" positive, woman was admitted to the hospital on October 30, 1980 with labor pains but without rupture of the membranes. For a day and a half two weeks prior to admission, she had suffered from headache, fever, abdominal pain, vomiting and diarrhea.

At physical examination the patient appeared to be a normally nourished and developed pregnant woman with no complaints except regular contracting pain. Her temperature was 100.2 F, pulse 84, respiration 18, and blood pressure 130/70 mm Hg. The external os was three fingers dilated and the uterine size was compatible with 35 weeks gestation. The fetal heart beat was normal. Remainder of the examination was unremarkable. The complete blood count revealed a leukocytosis (20,000 per cu mm with 56% segmented neutrophils, 16% band forms, and 27% lymphocytes). The urinalysis was normal.

After 14 hours, a 5 pound $\frac{1}{4}$ ounce girl was born with Apgar score of seven and of eight five minutes later. The baby appeared normal, but there were exceptions. The liver was palpable 4-5 cm below the right costal margin. There was peripheral cyanosis of the hands and feet, her cry was weak and high pitched, and the reflexes were diminished. A maculopapular rash was generalized over the entire body, but no petechiae were seen. Rate of respiration was 66 per minute with mild retractions. The temperature was 98°F.

The baby appeared sick and oxygen (35%) was administered. Measurement of blood gases revealed pO_2 150, pCO_2 27, and pH 7.3. Infusion of dextrose/water 10% through the peripheral vein was begun at a rate of 6 cc/hr.

Cultures were taken from the nose, external ear canal, blood, and spinal fluid. The spinal fluid was slightly xanthochromic with a protein 86 mg%, sugar 136 mg%, Cl 116 mEq/L, WBC 92 with 52% monocytes

and 48% polymorphonuclear leukocytes. A gram stain of the spinal fluid showed no organisms. The blood sugar was 115 mg%, CBC hemoglobin 18, hematocrit 52, WBC 5,200 with 35% segmented neutrophils, 3% band forms, 68% lymphocytes, and 4% monocytes. The platelet count was 81,000 per cu mm; VDRL nonreactive. The Torch profile revealed toxoplasmosis antibody titer zero, cytomegalovirus antibody titer zero, HSV-1 positive, HSV-2 negative, and rubella antibody titer 32. The chest x-ray showed no abnormalities. Urinalysis revealed 1+ albumin and 10 to 20 WBC/HPF.

As soon as all cultures were taken, the baby was placed on ampicillin 200 mg/kg/day intravenously and gentamycin 5 mg/kg/day intramuscularly. The next day there were several transient seizures, but the baby was less tachypneic. Her cry was less high pitched and the skin rash had begun to fade.

The mother's temperature rose to 103.4°F with chills. Ampicillin was administered 1 gm every six hours intravenously after a blood culture specimen had been obtained. The culture was negative.

On the third day the baby's rash was almost gone, and her cry became normal in character. The same day, cultures from the nose, ear, blood and spinal fluid grew gram positive rods subsequently identified as *Listeria monocytogenes*.

After two weeks of antibiotic treatment, the baby made a complete recovery and was discharged from the hospital weighing 4 pounds 15½ ounces. She was doing well at follow-up three weeks and again at two months.

Pathological examination of the placenta revealed acute and chronic chorioamnionitis with bacterial colonization. The mother's Torch profile was similar to that of the baby.

Discussion

Congenital listeriosis is defined as an intrauterine infection acquired either by the transplacental or ascending route. The majority of women who give birth to babies with congenital listeriosis have a "flu-like" illness with fever, malaise, abdominal pain, and backache before delivery, but some are asymptomatic.²

Clinical manifestations of congenital listeriosis are quite variable; however, most babies are premature and exhibit asphyxiation, respiratory distress, fever, erythematous and maculopapular rash, petechiae, jaundice, lethargy, vomiting, pulmonary infiltrate, cyanosis, and hepatomegaly. Transplacental or ascending spread of *Listeria* may cause spontaneous abortion, intrauterine

The Author

S. C. HUANG, M.D.

Dr. Huang is a pediatrician practicing in Plant City.

death, premature labor and delivery, neonatal sepsis and death.

Robertson et al reported a pregnant woman who was diagnosed as having listeriosis by positive blood culture during the third trimester. After successful treatment with ampicillin and gentamycin she delivered a low birth weight baby without listeriosis.³

Conclusion

The pregnant woman with "flu-like" symptoms should be investigated for possible listeriosis. If listeriosis is found, the mother should be treated to prevent the disease from being passed on to her baby. In the newborn, when listeriosis is suspected clinically, treatment consisting of a combination of parenteral ampicillin 200 mg/kg/day and gentamycin 5 mg/kg/day should be

started immediately and continued for two to three weeks if cultures are positive.

A high suspicion of neonatal listeriosis cannot be overemphasized. Moreover, the laboratory should be alerted when *Listeria monocytogenes* is suspected. In the newborn nursery the patient should be isolated until cultures are final because of the possibility of cross infection.

References

1. Storrs, C.N. and Partridge, J.W.: Correspondence, *Arch. Dis. Child.* 55:246, 1980.
2. Halliday, H.L. and Hirata, T.: Perinatal Listeriosis — Review of Twelve Patients, *Am. J. Obstet. Gynecol.* 133:405-410, 1979.
3. Robertson, M.H.; Mussalli, N.G.; Aizad, T.A.; Okaro, J.M. and Banwell, G.S.: Two Cases of Perinatal Listeriosis, *Arch. Dis. Child.* 54:549-551, 1979.

● Dr. Huang, 1608 West Oak Avenue, Plant City 33566.

National Institutes of Health Consensus Development Conference Statement

Coronary Artery Bypass Surgery: Scientific and Clinical Aspects

A Consensus Development Conference was held at the National Institutes of Health on December 3, 4, and 5, 1980. The purpose of the conference was to consider the status of coronary artery bypass surgery in relation to five specific questions:

1. What is overall management of patients with coronary artery disease — that is, in what context should coronary artery surgery be considered?
 2. What constitutes a reasonable diagnostic workup before recommending medical or surgical therapy?
 3. What is known about long-term survival with coronary artery bypass surgery in specific patient groups?
 4. What is known about long-term quality of life following coronary artery bypass surgery?
 5. What is the range of success rates for the procedure in various settings, and what factors may be important in influencing this outcome?
-
1. **What is overall management of patients with coronary artery disease — that is, in what context should coronary artery surgery be considered?**

Coronary heart disease may be recognized by the physician as the clinical syndromes of angina pectoris, acute myocardial infarction, sudden cardiac arrest or ischemic cardiomyopathy. It may also be recognized in an asymptomatic form by detection of electrocardiographic evidence of prior myocardial infarction not recognized during the acute episode or by characteristic abnormalities of the electrocardiogram during exercise testing of apparently healthy persons. Once suspected by the physician, the diagnosis may be confirmed with various levels of certainty by utilization of one or more

special diagnostic tests. The tests most commonly used include the electrocardiogram recorded during and after monitored graded exercise, in some institutions radio-nuclide studies of myocardial perfusion and ventricular function at rest and in response to exercise, and coronary arteriography with left ventricular angiography. In addition to confirming the diagnosis, such studies may provide information as to the pathological anatomy of the coronary arteries, the functional condition of the left ventricle and the overall response of the circulation to stress. These data may be combined with those obtained from the medical history and physical examination and with detailed knowledge of the natural history of the disease derived from many long-term follow-up studies of patients having such testing to form definable subsets of persons with widely different prognoses. Such a fundamental aspect of advanced coronary heart disease is a greatly increased probability of sudden death or myocardial infarction, such prognostic information strongly influences the decision on whether to add coronary artery bypass surgery to the overall lifelong medical management recommended. If the combined data indicate that the patient is at high risk of sudden death or infarction — for example, the patient with severe stenosis of the main trunk of the left coronary artery or severe and proximal stenosis of multiple major coronary branches — especially serious consideration is given for surgery. On the other hand, if the studies indicate that there is no critical stenosis of any major coronary branch, then clearly surgery is not indicated and medical treatment is advised.

But a very large percentage of patients fit between these extreme examples. In these patients, recommendations for medical or surgical therapy are based upon two fundamental questions. One question, often most

anxiety provoking to the patient, relates to the perception of the physician and the patient as to which course provides the greatest protection from disabling myocardial infarction or death. The second question relates to which course will allow the patient to obtain a satisfactory quality of life according to his own standards. The answers to these questions remain highly judgmental. The answer to the first is heavily based upon the physician's interpretation of a large volume of sometimes contradictory data of extraordinary complexity. The answer to the second is heavily based upon the individual patient's response to medical therapy and to his or her priorities.

It is common practice for the physician and patient, when faced with this problem, to initiate comprehensive medical therapy with subsequent periodic reevaluation of the patient's response to his treatment. It is critically important to recognize that appropriate, comprehensive medical care of the patient with coronary heart disease requires an intensive effort on the part of the physician, involving consideration of almost every aspect of the patient's life. It requires careful education of the patient and spouse on the nature of the disease and its management so as to allow adequate self-care on a continuing basis and to allow the patient to participate knowledgeably in major decisions affecting his or her life. It requires optimal control of risk factors for atherosclerosis and modification of lifestyle appropriate to the constraints imposed by the illness. This may affect both work and leisure activities. It may require long-term administration of such potent medications as nitroglycerin, beta-adrenergic blocking drugs, long-acting nitrates, antiarrhythmic agents and digitalis, among others. Effective and safe utilization of these therapeutic agents requires careful titration of dosage against both subjective and objective indices. If, after such careful and intensive medical treatment, the patient believes that the quality of life is so adversely affected that other alternatives must be sought, then surgical therapy may be advised in patients suitable for this operation. It must also be recognized that in many cases dissatisfaction with the altered lifestyle imposed by the illness is the result of inadequate attention to the details of management; failure of the physician to educate the patient concerning appropriate use of the indicated medications may be a particularly important cause of this outcome.

In patients with chronic stable angina and good ventricular performance, aorto-coronary revascularization of the heart, whether with autologous vein or artery, has had a progressive decline in operative mortality to levels as low as 1 to 2 percent at major surgical centers. A corresponding decrease in perioperative myocardial infarction has been achieved. These results are assumed to relate to better management of anesthesia, more com-

plete myocardial revascularization and improved methods for protecting the heart during the period of coronary grafting. There seems to be no doubt that coronary bypass surgery can improve myocardial perfusion. Patency of aorto-coronary saphenous vein grafts has been in the range of 80 to 85 percent two years after operation. The procedure has been widely accepted as treatment in patients with unacceptable symptoms on medical therapy and in certain other subsets of patients with coronary artery disease.

2. What constitutes a reasonable diagnostic workup before recommending medical or surgical therapy?

A reasonable diagnostic workup of a patient with angina pectoris depends upon the clinical problem at issue. Instability and severity of angina, effect of disease on the quality of life, cardiac function and, to a certain degree, age plays a role in determining the workup of each patient. The workup should be done as efficiently as possible to provide definitive information upon which clinical decisions can be made. Unnecessary and redundant procedures should be avoided.

In some patients the clinical picture indicates the need for anatomic definition of the coronary anatomy to determine operability. There is consensus that patients with stable angina whose quality of life is significantly impaired by their symptoms should undergo coronary arteriography. Further, in patients with unstable angina, coronary arteriography should be performed during the initial phase of hospitalization; if maximal medical therapy does not relieve symptoms, this procedure should be done urgently. There is consensus that coronary artery bypass graft surgery is indicated in patients with unacceptable symptoms on appropriate medical treatment or with recurrent unstable angina, but the decision to operate must also depend on results of invasive studies.

In patients with typical angina not sufficiently severe to dictate surgery for relief of symptoms, noninvasive cardiac testing may be carried out initially in the attempt to identify those at high risk for major cardiac events. However, there is a lack of consensus on the value of noninvasive testing in the workup of such patients. Some physicians prefer coronary arteriography as the initial diagnostic procedure, particularly in the young patient. Others recommend exercise electrocardiography in an attempt to identify patients with significant left main or triple-vessel disease. Such patients will often show early and/or excessive ST segment deviations, prolonged ST segment depression into the recovery period, or decrease in blood pressure during the test. In this category of patients, coronary arteriography should be carried out and, if high-risk pathology is found, coronary artery bypass

surgery considered. The use of radionuclide studies to identify high-risk patients with left main and/or triple-vessel coronary disease needs further evaluation.

There is lack of consensus on the approach to evaluation of patients with questionable or atypical angina. In such patients exercise electrocardiography may be helpful in the identification of those with significant coronary disease; such identification may be enhanced by radionuclide studies in conjunction with exercise testing, particularly in patients with resting electrocardiographic abnormalities which impair the interpretation of the exercise electrocardiogram. The presence of coronary artery disease may be indicated by transient myocardial perfusion defects, wall motion abnormalities or an abnormal response of the left ventricular ejection fraction to exercise. Further research is needed to determine the role of noninvasive testing in patients with, or those suspected of having, coronary-artery disease.

Survivors of an acute episode of myocardial infarction are at high risk of sudden death during the first year after the infarction. Recent studies have demonstrated one-year mortality ranging from 10 to 15 percent of all survivors. Several investigators have reported that these patients can be divided into high and low-risk subgroups on the basis of clinical information and such noninvasive testing as exercise electrocardiography, radionuclide studies of ventricular function, and ambulatory 24-hour electrocardiographic recording. It is believed that high-risk patients should undergo coronary arteriography and left ventricular angiography followed by surgical intervention if the coronary anatomy and left ventricular function are appropriate. It should be recognized however, that the course of these patients undergoing surgery may differ from that of patients with stable or unstable angina and apparently similar coronary anatomy and ventricular function, in that they appear to exhibit a greater tendency for major ventricular arrhythmia. It is also recognized that there is as yet insufficient data to determine whether surgical intervention will reduce the mortality of this special subset of patients with coronary heart disease. Because of the relatively large number of patients included in this high-risk post-myocardial infarction subset, and the present uncertainty as to the proper course of management, an urgent need exists for further investigation of this problem.

The problem of the patient with coronary disease presenting with congestive heart failure needs special consideration. It is important to determine whether a lesion amenable to surgery is contributing significantly to the heart failure, e.g., a ventricular aneurysm, severe mitral incompetence and/or a post-myocardial infarction ventricular septal defect. Two-dimensional echocardiography or radionuclide ventriculography may be

noninvasive techniques of help in the evaluation of such patients.

3. What is known about long-term survival with coronary artery bypass surgery in specific patient groups?

The impact of coronary artery bypass surgery on survival of patients with coronary artery disease has been the focus of extensive debate since its introduction. In considering data on survival, the severity of left ventricular dysfunction has been determined to have an adverse effect on survival, and comparisons between surgical and medical therapy must take this into account as well as the anatomic location and extent of disease defined by coronary arteriography.

It is well recognized that the interpretation of the results of surgical series by comparison with historical controls is difficult. It is especially hazardous in the assessment of coronary artery surgery because of marked changes between early and recent results, both for surgically treated and for medically treated patients. Several recently published series with long-term follow-up of patients undergoing coronary artery bypass surgery have documented an impressively low operative mortality with remarkable long-term survival. At the same time, other studies have noted a marked improvement in recent years in the survival of medically treated patients. Accordingly, it seems unlikely that convincing evidence of the benefits of surgery in appropriately defined subgroups can be effectively assessed from other than adequately controlled studies.

There is consensus that coronary artery bypass surgery in patients with angina pectoris and greater than 50 percent narrowing of the luminal diameter of the left main coronary artery results in improved survival when compared with results on medically treated patients regardless of left ventricular function or degree of angina pectoris. (Survival rates with medical and surgical therapy were 60 and 89 percent respectively at four years in the V.A. trial, and 67 percent and 89 percent at five years in the European trial. Left main coronary artery stenosis of this severity is reported in approximately 10 percent of patients undergoing coronary arteriography.*)

There are only a few prospective randomized trials and observational studies with concurrent medically treated controls to assess the impact of surgery on survival. Furthermore, the application of such results to the overall population with symptomatic coronary artery disease, treated in a variety of centers, must be done with caution. This compounds the problem of judging the

*Estimates of prevalence of lesions found on coronary angiography have a significant dependence on the criteria for angiography; thus considerable variability may exist among individual institutions.

effects of coronary artery bypass surgery on survival in patients with three-vessel disease for whom conflicting data exist. (Three-vessel coronary artery disease of surgical significance is reported in 30 to 40 percent of angiographic studies.*) The V.A. Cooperative Randomized Trial was reviewed. The initial report failed to demonstrate improved survival with surgery in patients with three-vessel disease, the majority of whom had moderate impairment of left ventricular function. However, if one accepts the analysis of the V.A. data for the 10 hospitals (which include 87 percent of the patients) in which the average operative mortality was 3.4 percent and eliminates the three outliers in which the average operative mortality was 23 percent, a significantly improved survival with surgery is observed. There is evidence from observational studies which suggests improved survival in patients with three-vessel disease and moderate impairment of global left ventricular function, i.e., left ventricular ejection fraction in the range of 25 to 50 percent.

Data were reviewed that suggested improved survival after coronary artery bypass grafting in patients with three-vessel disease and good left ventricular function defined as left ventricular ejection fraction greater than 50 percent. The European Collaborative Randomized Trial demonstrates improved survival for surgically treated patients in this subset. Though the differences observed in the European trial are impressive (survival rate at 60 months was 82 percent for the medical group and 94 percent for the surgical group), there is consensus that confirmation of these findings by additional studies is needed before a firm conclusion can be reached on the question of improved survival in patients with three-vessel disease and good left ventricular function as defined. Other smaller randomized trials and observational studies have yielded conflicting results in this subset.

The two large randomized studies examined do not provide evidence for improved survival with surgery of patients with two-vessel disease regardless of the status of the left ventricle, while some observational studies have suggested improvement in survival with surgery of patients with two-vessel disease and moderate impairment of left ventricular function. There is no evidence currently available to support improved survival after surgery in patients with single-vessel disease regardless of left ventricular functional status.

We do not find data adequate to support the conclusion of improved survival with surgery in patients with severe degrees of left ventricular functional impairment, i.e., left ventricular ejection fraction less than 20 percent.

Review of the National Heart, Lung, and Blood Institute Multicenter Randomized Unstable Angina

Pectoris Trial, which excluded patients with left main coronary artery disease or persistent unstable angina, has failed to show improved survival of those treated by urgent surgery compared to those treated exclusively by medical management unless surgery was dictated by chronic symptomatology. The extent to which results in this highly selected group of patients can be extrapolated to other subsets of unstable angina patients is not established.

It is important to reemphasize that surgery may still be appropriate in patient subsets where evidence of improved survival with surgery is lacking if symptoms of myocardial ischemia are sufficiently severe or if large areas of myocardium are in jeopardy. Further attempts should be encouraged at identifying other variables, currently unmeasured, which may affect survival and thus provide methods for more critical testing of therapeutic effectiveness.

4. What is known about the long-term quality of life following coronary artery bypass surgery?

There are few objective criteria by which quality of life can be assessed following coronary artery bypass surgery. The symptom of angina pectoris is reported to be relieved in 80 to 90 percent of patients undergoing operation for chronic stable angina. Bypass surgery has reduced the subsequent number of cardiac-related events, amount of medication required and frequency of hospitalizations. The majority of postoperative patients have been able to increase their exercise capacity and their New York Heart Association functional class. This has been documented by improvements in functional exercise testing, angina threshold, left ventricular wall motion, left ventricular ejection fraction during exercise, indices of myocardial oxygen consumption during exercise and greater lactate extraction across the myocardium.

Improvements in symptoms and functional capacity associated with coronary bypass surgery theoretically should result in more individuals returning to gainful employment. The consensus is that this expectation has not been accomplished. It is recognized that physicians do not make consistent recommendations to patients regarding exercise potential and employability after successful coronary bypass surgery. Factors extraneous to the patient-physician relationship such as preoperative work status, availability of nonwork income, preception of health, age, level of education, and employer attitudes all appear to influence the postoperative employment status. Whether or not the patient returns to work after coronary bypass surgery depends on too many nonmedical factors to allow any conclusions regarding efficacy of therapy based on this parameter.

*Estimates of prevalence of lesions found on coronary angiography have a significant dependence on the criteria for angiography; thus considerable variability may exist among individual institutions.

It is reported that angina will recur or progress after bypass surgery in about 5 percent of patients per year. In approximately two-thirds of these patients, symptoms are related to closure of the vein graft or progression of disease in the native circulation. This may be related to persistent elevation of blood lipids or poor control of other risk factors. The entire question of mechanisms involved in progression of atherosclerosis in the coronary circulation and in grafts is important and requires further investigation.

Similar results regarding quality of life have been observed in patients undergoing coronary bypass surgery for unstable angina, but the reported follow-up data are of shorter duration than those cited, which are based predominantly upon patients with stable angina.

5. What is the range of success rates for the procedure in various settings, and what factors may be important in influencing this outcome?

The institutional setting in which bypass graft surgery is performed may importantly influence the rate of success of the operation in various clinical subgroups. Excellence can be achieved in a variety of hospital settings provided appropriate medical and technical support is available to complement an experienced and skilled surgical team. This would include expertly performed angiography in suitably equipped laboratories, the availability of other subspecialty resources and appropriate laboratory and blood banking facilities.

Successful intraoperative management, reflected in low rates of mortality, perioperative infarction and other postoperative complications, and short hospital convalescence will depend not only upon surgical skill and judgment, but also upon the availability of competent anesthesiologists, efficient extracorporeal support, optimal myocardial preservation techniques and minimal duration of myocardial ischemia consistent with optimal revascularization.

Postoperative management requires a suitable intensive care facility, dedicated personnel and the availability of circulatory support systems.

With the experience that has been accumulated to date, the following expectations for hospital mortality and perioperative infarction are achievable:

- In patients with chronic stable angina pectoris and normal or moderately impaired left ventricular function, a hospital mortality rate of 4 percent is generally attainable, and a rate of less than 1 percent is possible. The incidence of electrocardiographically documented perioperative infarction might approximate 5 percent.
- In the syndrome of unstable angina pectoris, early results will depend upon the institution's approach

to management. A somewhat higher incidence of morbidity and mortality may result from earlier operative intervention compared to lesser risks after a longer period of stabilization and exclusion of patients with evolving infarctions. With initial stabilization and nonemergency operation, hospital mortality and perioperative infarction rates should approach those for patients with chronic stable angina pectoris. Even with early intervention, a hospital mortality of 6 percent is generally attainable, and perioperative infarction might approximate 10 percent.

- The existence of left main coronary artery involvement has been associated with high operative risks in the past. Currently, and except under emergency conditions, individuals with this lesion can be operated upon with morbidity and mortality rates only slightly higher than for those with chronic stable angina with other coronary anatomy.
- Bypass grafting in patients with severe left ventricular dysfunction has been associated with high operative morbidity and mortality. Recent improvements in perioperative management have lessened the risks. In patients with very severe myocardial dysfunction — that is, ejection fractions of less than 25 percent — a hospital mortality rate no greater than 15 to 20 percent is generally achievable.
- At this time there is insufficient information to identify the role of bypass surgery in patients with acute myocardial infarction, intractable ventricular arrhythmias or asymptomatic patients with jeopardized myocardium.

For all categories of patients, average one-year graft patency of 85 to 90 percent should be achievable. The roles of anticoagulant and antiplatelet therapy, as well as other interventions which may affect late graft patency and retard the arteriosclerotic process are not known at this time and require further study.

Conclusion

There is consensus of the Panel that coronary artery bypass surgery represents a major advance in the treatment of patients with coronary artery disease. Evidence has been presented to support the conclusion that improvement in the quality of life, decreased myocardial ischemia, and increased survival in selected subsets of patients have been demonstrated following coronary artery bypass surgery.

The Consensus Conference on Coronary Artery Bypass Surgery: Scientific and Clinical Aspects was sponsored by the National Heart, Lung, and Blood Institute in conjunction with the National Center for Health

Care Technology and with the assistance of the Office for Medical Applications of Research, Office of the Director, NIH. The Consensus Development Panel consisted of the following persons:

Robert L. Frye, M.D. (Chairman)
Chairman, Division of Cardiovascular Diseases
Mayo Clinic
Rochester, Minnesota

W. Gerald Austen, M.D.
Chief of Surgical Services
Massachusetts General Hospital
Boston, Massachusetts

Paul A. Ebert, M.D.
Professor and Chairman
Department of Surgery
University of California
San Francisco, California

Charles K. Francis Jr., M.D.
Assistant Professor of Medicine
Co-Director, Cardiac Catheterization Laboratory
Division of Cardiology
Yale University School of Medicine
New Haven, Connecticut

Nicholas T. Kouchoukos, M.D.
Professor of Surgery
University of Alabama in Birmingham
Birmingham, Alabama

Paul Meier, Ph.D.
Department of Statistics
University of Chicago
Chicago, Illinois

Hiltrud S. Mueller, M.D.
Professor of Medicine and Chief of Cardiology
St. Louis University School of Medicine
St. Louis, Missouri

Elliot Rapaport, M.D.
Professor of Medicine
University of California, San Francisco
San Francisco, California

T. Joseph Reeves, M.D.
Director, Cardiovascular Laboratory
St. Elizabeth's Hospital
Beaumont, Texas

David C. Sabiston Jr., M.D.
Professor and Chairman
Department of Surgery
Duke University Medical Center
Durham, North Carolina

William C. Sheldon, M.D.
Chairman, Department of Cardiology
Cleveland Clinic Foundation
Cleveland, Ohio

Robert L. Vitu, M.D.
Saginaw, Michigan
Assistant Clinical Professor of Family Practice
College of Human Medicine
Michigan State University
East Lansing, Michigan

James H. Ware, Ph.D.
Associate Professor of Biostatistics
Harvard School of Public Health
Boston, Massachusetts

Special participants in the discussions of the Panel included the following:

Samuel Gorovitz, Ph.D.
Chairman, Department of Philosophy
University of Maryland
College Park, Maryland

David C. Levin, M.D.
Associate Professor of Radiology
Harvard Medical School
Boston, Massachusetts

William B. Stason, M.D.
Associate Professor of Health Policy and Management
Harvard School of Public Health
Boston, Massachusetts

Commentaries on the Consensus Conference on Coronary Artery Bypass Surgery

Henry D. McIntosh, M.D.
Cardiology Division, Watson Clinic
Lakeland, Florida

In 1968, Favaloro and his associates at the Cleveland Clinic demonstrated that coronary artery bypass surgery (CABS) could be performed with a low operative mortality and a high incidence of relief of pain.¹ It has been estimated that, during the first decade following that observation, up to 500,000 such operations were performed.² Because coronary artery disease is the leading cause of death in developed societies, it is not surprising that such a procedure should be welcomed with widespread enthusiastic support. It is now estimated that at least 100,000 individuals in the United States each year undergo the operation in 581 hospitals.

The operation costs at least \$15-20,000; the annual national expenditure is, therefore, about two billion dollars.³ CABS accounts for nearly 1% of all health expenditures in this country. The question may well be asked: "Is it worth it?" This was one of the underlying questions that prompted the NHLBI to hold a Consensus Conference last fall, the report of which is published in this Journal. This writer was privileged to have been invited to be a participant at this conference.

Webster defines a consensus as reflecting "group solidarity and sentiment and belief" . . . it implies "general agreement" . . . "unanimity". An NHLBI Consensus Conference brings together knowledgeable clinical and laboratory scientists for the purpose of determining what is known about the current "state of the art" of a procedure, or therapy, or disease. The goals of such conferences are carefully defined. Discussion in this conference was limited to seeking the answers to five specific questions.

Certain conclusions permeated the discussion of all questions and deserve emphasis. First, it was accepted that CABS represents a major advance in the treatment of patients with coronary artery disease. But, secondly, it was repeatedly emphasized that the disease was a life-

long progressive process and that it was not "cured" by CABS. The operation might be considered a "stay of execution . . . it could not be considered a pardon".²

Major attention was directed to what was known as to how successful the procedure is in protecting a patient from disabling myocardial infarction and death. Thus, question #3 (What is known about the long-term survival after coronary bypass surgery in specific patient groups?) occupied the greatest attention. It was concluded that CABS improves survival in symptomatic patients with more than 50% narrowing of the luminal diameter of the left main coronary artery regardless of the left ventricular function. There was also a reasonable consensus that the procedure statistically postponed premature death in patients with significant three-vessel disease and moderate impairment of global left ventricular function; i.e., left ventricular ejection fractions in the range of 25-40%. There was no consensus to support the use of the procedure for the purpose of prolonging life or preventing myocardial infarction in anatomically or functionally less extensive disease.

It was concluded that the procedure, however, does have a role in assuring a satisfactory quality of life "according to the patient's own standards". Its use will vary depending on the individual's response to medical therapy and on the patient's priorities. The role of CABS for such purposes can frequently be determined only after long and careful therapeutic efforts. It was concluded that there is little justification in most patients for the mere diagnosis of coronary artery disease catapulting the patient to the operating room.

It was emphasized that "it is critical to recognize that appropriate, comprehensive medical care of the patient with coronary artery disease requires an intensive effort on the part of the physician, involving consideration of almost every aspect of the patient's life. It requires careful education of the patient and the spouse on the nature of the disease and its management to allow adequate self care on a continuing basis and to allow the patient to participate knowledgeably in major decisions affecting his or her life. It requires optimal control of risk

factors for atherosclerosis and modification of the patient's lifestyle. This may affect both work and leisure activities. It may require long-term administration of such potent medications as nitroglycerin, beta-adrenergic blocking drugs, long-term nitrates, antiarrhythmic agents and digitalis. Effective and safe use of these therapeutic agents requires careful titration of dosage according to subjective and objective indices. If, after such careful and intensive medical treatment, the patient believes that the quality of life is so adversely affected that other alternatives must be sought, then surgical therapy may be advised".

It should be emphasized that it was agreed that CABS did **not** result in more patients returning to gainful employment than patients with coronary artery disease who did not have surgery. Florida appears to be fast becoming "populated" with people who have evidence of coronary artery disease that has been treated promptly by surgery and the patients have retired and moved to Florida. It was agreed, however, that nonmedical factors are frequently important in prompting patients to retire. Furthermore, it was agreed that angina will recur or progress after bypass surgery in about 5% of patients per year. In approximately two-thirds of these patients, symptoms are related to closure of the vein graft or progression of disease in a native circulation.

Finally, it was emphasized by the Consensus Committee that the mortality and the incidence of perioperative and postoperative complications from CABS vary from institution to institution and from surgeon to surgeon. In patients with "chronic stable angina pectoris and normal or moderately impaired left ventricular function, a hospital mortality rate of 4% is generally attained and a rate of less than 1% is possible . . . the incidence of electrocardiographically demonstrated perioperative infarction may approximate 5%". The physician referring a patient for CABS must, therefore, be concerned about the overall results and competency of his surgeon. This can vary widely.

This conference was useful in sorting out what is known from what is unknown and suspected about the effect of CABS in the overall management of coronary artery disease. Clearly, the procedure should not be considered the cornerstone of therapy or the first line of defense against the disease. But, clearly, it must be considered an important addition to the overall management of the patient with coronary artery disease.

It must be appreciated that during the last decade or two a gratifying decline in the incidence of death from coronary artery disease has occurred. The decline appears to have begun in the mid 1960s but it may have started sooner in certain areas of the country, especially among white women.⁴ Since 1968, the downward trend has encompassed men and women, whites and blacks,

and all adult ages, with the overall rate of decline being greatest among black women. If the death rates recorded in 1968 still existed in 1977 when the population of the country was larger and older, 630,000 additional deaths would have occurred between 1968 and 1976; 191,500 additional deaths would have occurred in 1977 alone. During this period, the death rate for coronary artery disease has increased in other countries except Australia, Belgium, Canada and perhaps England, Finland, Israel and Japan. The decline, if any, in the incidence in these countries is small compared to that in the United States.

A recent report by The Metropolitan Insurance Company indicates that the degree of decline in mortality apparently varies among socioeconomic strata in our society.⁵ Mortality has decreased more among urban, predominantly white, middle-class males than among nonwhites in lower socioeconomic strata. From 1969 to 1977, age-adjusted death rates from cardiovascular disease among white men in the general population fell 19%, from 459 to 367 per hundred thousand population; among insured men, the decline was 31%, from 387 to 296 per thousand population. In 1969, the mortality rate among insured men was 18% lower than among white males in the general population, but by 1977 the difference was 37%. During the same period, the death rates declined 24 and 26%, respectively, among women in general and in the insured populations.

The cause of decline is uncertain. Although primary prevention through changes in risk factors, as well as better medical care, made possible by fundamental and clinical research, probably have contributed, they do not fully explain the decline. The relatively widespread use of CABS appears to have had little influence on this trend. Stern concluded that, even according to the most generous assumptions, surgery could not have contributed more than 4 to 5% to the total salvage of life.⁶

Based on these observations, it would appear that the physician seriously concerned about reducing the mortality from coronary artery disease should direct his major efforts towards stimulating his patients to modify their lifestyles so as to eliminate risk factors thought to contribute to the progression of the disease. Such efforts would appear to have widespread effects. Although clearly a significant advance, CABS can have only limited effect in selected patients afflicted with this devastating disease.

References

1. Favaloro, R.G.: Saphenous Vein Autograft Replacement of Severe Segmental Coronary Artery Occlusion: Operative Technique. *Ann. Thorac. Surg.* 5:334, 1968.
2. McIntosh, H.D.: Overview of Aortocoronary Bypass Grafting for the Treatment of Coronary Artery Disease: An Internist's Perspective. National Center for Health Care Technology Monograph Series. Jan. 1981, Bethesda, MD.
3. Coronary Artery Bypass Surgery: Economic, Ethical, and Social Issues. Summary of Pro-

- ceedings of First Technology Assessment Forum National Center for Health Care Technology. Apr. 21-23, 1981, Washington, D.C.
4. Proceedings of the Conference on the Decline in Coronary Heart Disease Mortality. NHLBI, NIH, Bethesda, MD, Oct. 24-25, 1978.
 5. Metropolitan Life Insurance Company: Recent Trends in Mortality from Cardiovascular Disease. Statistical Bull. 69: (No. 2), 1979.
 6. Stern, M.P.: The Recent Decline in Ischemic Heart Disease Mortality. Ann. Int. Med. 91:630, 1979

James R. Jude, M.D.
Cardiothoracic Surgical Associates
Miami

The Consensus panel seems to cover well and have a common consensus in regard to the superiority of surgery over medical therapy in left main and triple vessel disease in symptomatic or non-symptomatic patients. They skirt the issue of true prophylactic coronary bypass grafts, in patients funneled into the diagnostic and therapeutic river, by having exercise stress-testing as part of an annual physical examination. In review of the substantial number of patients who die of their first cardiac event, in the absence of evident previous symptoms, this group becomes important for recognition either by exercise stress testing all patients who reach the heart-attack prone age (over 45 years) or are of a high risk profile (family history, metabolic conditions or life style).

Once a patient, by whatever criteria, brought into the stream, is found to have evidence of coronary disease, then he should have further studies to define the extent of the disease. I favor, and it would appear the majority of the Consensus panel does advise, going straight to cardiac catheterization and coronary arteriography. In this manner we learn both the anatomy and the functional physiology of the heart. Noninvasive studies leave too many questions, add expense and perform as a delaying tactic.

Once the anatomy and functional physiology have been defined the patient can be placed into subsets prognostic of the future and from which therapy formed as well as life style for that particular patient. Medical versus surgical treatment will depend upon the findings. In left main or significant triple vessel disease, revascularization is indicated even though this course has evolved from an asymptomatic patient. This must be an individual approach based on the risk of surgery versus the physicians own experience. My own view is that the risks of surgery are almost zero in such patients with good ventricular function while I have seen many patients die within one to two years from their first obvious cardiac event (e.g. high grade mid left anterior descending artery stenosis and no other significant coronary artery disease).

I believe the Consensus panel brings out a very important area of need for marked improvement versus the post-infarction group where there is a 10-15% death

rate in the first year. Obviously **all** of these patients, in the absence of other serious medical or age consideration should have cardiac catheterization. The 10-15% subset should be defined and treated surgically. There is usually found a further subset in which the mortality is far higher than the 10-15% and where the yield from surgery is highly significant.

The operative mortality and peri-operative morbidity as outlined is low and generally obtainable and indeed must be obtained if this type of surgery is to be performed in any institution whether private or academic.

C. Richard Conti, M.D.
Professor of Medicine,
Chief, Division of Cardiology
University of Florida

The NIH consensus report on Coronary Artery Bypass Surgery is a well thought out and clearly written summary of a great deal of work by numerous investigators. It should be read by all physicians responsible for patients with ischemic heart disease. Perhaps it should be rewritten in lay terms for distribution to patients as well.

From my perspective, the evidence is overwhelming that successful bypass of a severely stenotic coronary artery increases blood flow to previously ischemic myocardium and renders it non-ischemic. Thus, symptoms decrease and normal ventricular function is maintained and by that mechanism, presumably myocardial infarction, serious arrhythmias and sudden death are prevented. The operation makes sound physiologic sense (as opposed to previous attempts at myocardial revascularization) and is clearly warranted in patients who continue to be symptomatic despite optimal medical therapy.

Although the obvious goal of any therapy, medical or surgical, is to prolong life, it is naive to believe that surgery is being recommended **solely** to accomplish that goal. The problem that all of us face as physicians caring for patients is that none of us is able to predict who will die and who will survive with either medical or surgical therapy. In fact, there are only two mortality rates that apply to a specific patient, 0% and 100%. The best that any physician can do is to evaluate the population data and try to apply these data to his or her individual patient. Clinical trials random or otherwise should be used as **one piece of information** to help make clinical decisions about individual patients.

Many other factors, as outlined in the consensus report must be considered by the physician making therapeutic decisions in individual patients. At the present time, decisions for coronary bypass surgery in a pa-

tient must be based on (1) data available from published studies (such as VA NHLBI European Trials), (2) failure of medical therapy to control symptoms (ischemia),

(3) the patient's desire for surgical therapy (generally related to symptoms), (4) availability of competent surgical team with a low operative morbidity and mortality.

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal*.

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Abstract. All scientific manuscripts should include a 150 word, maximum length, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given:

names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request".

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double-spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication".

When received, the senior author will be sent an acknowledgement of receipt and a copyright agreement which must be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

What Became of the Rotating Internship?

What became of the rotating internship? That's a little like asking what happened to the five cent cigar, corner grocery, and twenty-five cent gasoline, now mere fragments in the collage of American nostalgia. Another question, perhaps more appropriate in this regard, might be to ask what happened to American passenger trains? Obviously, they went into decline, but now the public is becoming aware that the railroad is a fairly energy-efficient way of moving large numbers of people from one place to another, and railroads may be needed again. Their decline rested on a fragile premise of an inexhaustible energy supply, and this fostered the proliferation of petroleum-guzzling automobiles and jet aircraft. Times change, and many now wish for the return of the passenger train, but repair of the error is costly and this postpones the ultimate restoration. But how do passenger trains relate to rotating internships?

In the 1960's, the so-called Millis¹ and Coggeshall² reports were published. They attempted to analyze the status of American medicine 50 years after Flexner, and they made recommendations on how best to educate physicians in the context of increasing societal needs and demands and the burgeoning scientific knowledge and technology. These documents are recommended reading for those interested in the evolution of American medical education. Briefly, these reports concluded that there is simply too much to learn and too little time to learn it in. Consequently, the rotating internship was essentially abolished and replaced by straight internships. It is enlightening to look again at these reports.

The Millis report states: "The internship no longer provides the student's first practical experience with problems of diagnosis and treatment; that function is now served by undergraduate clinical clerkships."

Later, the report continues: "The needed new dimension is continuing and comprehensive care of high quality. Medical education must produce competent and broadly trained physicians to give that care." (The emphasis is mine.)

As a consequence of this thought, the committee recommended that "the internship, as a separate and distinct portion of medical education, be abandoned, and that the internship and residency years be combined into a single period of graduate medical education called a residency and planned as a unified whole."

The Coggeshall report states:

"The education of a physician must more and more include management and problem solving rather than encyclopedic capacity . . . The physician must now assume the role of team leader having the broad familiarity and competence to marshal the appropriate expertise and resources beyond his individual skill . . . Basic principles required for intelligent decision-making should compose the curriculum, with emphasis placed on problem-solving and the use of human and technological resources."

Finally, the Coggeshall report states:

"The vast accumulation of new knowledge makes it increasingly evident that not all medical information available can be conveyed in four years. There is need to develop a curriculum that provides for later specialization. There is need for re-examination of curriculum to eliminate both duplication and subject matter not essential to subsequent education and practice."

Both reports advocate broadly trained physicians imbued with basic principles to allow them to be team leaders in the complex medical care system. In other words, the rotating internship was eliminated to help facilitate the transfer of increasing medical information to physicians who should be broadly trained. This doesn't make sense unless one considers the internship to be a time-wasting, noneducational, irrelevant exercise.

Education, in any field, must begin with a broad base before it narrows into specialization. Formerly, the rotating internship served as a time for bringing together medical school teaching in an active, participating way. It afforded time and experience to help the new physician decide the course of a career. Although one might ultimately become an internist, the first-hand experience at the surgical table and wards would leave a depth of understanding, a "feel" much superior to that gleaned from reading or hearing. The same could be said of a surgeon's experience on a medical service. I have witnessed an increasing tendency for house officers to order inappropriate tests and consultations which I would ascribe to a lack of familiarity with general medicine. There is reluctance, if not fear, of performing even simple preliminary evaluations of an undifferentiated patient problem, which again I would attribute to a lack of general experience. The patient's problem is all too often divided into parts;

when one physician has taken care of his domain, he leaves for someone else to take over. Medicine simply cannot be fragmented with respect to the individual patient. Who will care for the whole patient?

I am not denigrating specialization, but I am criticizing the attitude that specialized knowledge and expertise must necessarily exclude general knowledge and expertise. I am critical of the concept that surgeons need know nothing of basic physical diagnosis, or that internists need no first-hand exposure to problems of the surgeon, or that the radiologist need never see a patient. I am saying that a year of broad, practical, hospital-based training immediately after medical school — formerly called the rotating internship — is, in the long view, cost-effective, in the best interests of our patients, and most consistent with the human learning process. A broad fund of knowledge and experience is the basis of one's quality of intuition, judgment, and imagination. By depriving physicians of the rotating internship experience — which I believe helps provide these — we may even be blunting the rate of general medical progress.

Recently, the Graduate Medical Education National Advisory Committee³ presented data indicating a present and future overabundance and maldistribution of specialists. This circumstance must have been, at least in part, fostered by the decline of the rotating internship.

To correct the problem, we will need to provide greater opportunities to newly graduated physicians for broad postgraduate training similar to rotating internships.

We need specialists, to be sure, but they are best produced on a broad base. Reinstitution of the rotating internship is an idea whose time has reappeared and probably should not have disappeared in the first place. I believe that the discussion should be reopened.

*Richard A. DeRemee, M.D.
Division of Thoracic Diseases
and Internal Medicine
Mayo Clinic*

Editor's Note: Dr. DeRemee is a Board-certified specialist in pulmonary diseases. He had a rotating internship. This editorial appeared originally in the June 1981 issue of *The Mayo Clinic Proceedings* and is reprinted here with permission.

References

1. Report of the Citizens Commission on Graduate Medical Education: The Graduate Education of Physicians. Chicago, American Medical Association, 1966.
2. Coggeshall, L.T.: Planning for Medical Progress Through Education. Evanston, Illinois, Association of American Medical Colleges, 1965.
3. Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services. Hyattsville, Maryland, Health Resources Administration, 1980.

Radio-TV Conference for Doctors Scheduled by AMA

The American Medical Association's office of public relations has announced the second annual Health Reporting/Radio-TV Conference, to be held in Fort Worth, Texas.

The Fort Worth Hyatt Regency will be the headquarters hotel for the session beginning on Thursday evening, October 29 and ending on Saturday, Oct. 31.

The conference is designed for physicians who have radio or television programs or who wish to begin such

programs. Speakers will include Dennis S. O'Leary, M.D., the Washington physician who skillfully handled reporters' questions about President Reagan in the aftermath of the attempt on his life last spring.

Registration fees are \$125 for members of the AMA and \$175 for non-members. Additional information may be obtained by contacting: Bobbie Craddock Lawrie, Office of Public Relations, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

ORGANIZATION

Florida Legislature to Convene Early; FMA Legislative/FLAMPAC Workshop Planned

The Florida Legislature will convene its 1982 Session three months earlier than usual to allow sufficient time at the close of the Session to address the subject of reapportionment. In order to be prepared for the start of the Session on January 18, the Florida Medical Association must finalize its 1982 legislative program and begin to develop contacts with legislators early this fall.

During its 1982 Session, the Legislature will consider several key issues, including sunset of the entire state insurance code, which contains many sections directly affecting the practice of medicine and the hospital licensure law. Several other issues of major concern to Florida physicians have been identified as possible FMA legislative priorities and include:

- Advanced and Registered Nurse Practitioners
- Opposition to state funding of HSA's
- Opposition to legislation authorizing Optometrists to prescribe drugs
- Sustain the Governor's veto of the I.A.T. bill (which will allow use of unorthodox forms of cancer treatment in Florida)
- Professional Liability

The FMA will sponsor a one-day Legislative and FLAMPAC Workshop on Saturday, October 24 at the Host Airport Hotel in Tampa to outline in detail the FMA's legislative priorities and to develop the necessary coordination and support needed to successfully carry out the legislative goals of the FMA. A portion of the workshop program will be devoted to FLAMPAC membership development and political education activities.

Attendance at this important conference is vital to the success of FMA legislative efforts both in achieving legislative objectives, and in helping to prevent enactment of proposed bills that would be detrimental to physicians as well as quality health care delivery. Any member of the FMA is invited and encouraged to attend the workshop, and should contact FMA Headquarters at (904) 356-1571 for further information.

The complete workshop program is as follows:

8:45 a.m.	Welcome and Introductory Remarks — Sanford A. Mullen, M.D., FMA President
9:00 a.m.	Keynote Speaker
9:25 a.m.	Outline of Major FMA Issues for 1982 — Louis C. Murray, M.D., Chm., Council on Legislation
10:00 a.m.	Panel Discussion on Sunset Review
11:20 a.m.	Refreshment Break
11:35 a.m.	Key Contact Physicians — James G. White, M.D., Chairman, Committee on State Legislation
11:50 a.m.	Role of the Auxiliary — Mrs. Joseph Saiter (Cheryl) Chairman, FMAA Committee on Legislation
12:05 p.m.	Recess
12:15 p.m.	Luncheon with Featured Speaker
2:00 p.m.	Panel Discussion on Redistricting
3:00 p.m.	Question and Answer Period
3:30 p.m.	FLAMPAC — Francis C. Coleman, M.D., President
	• Membership — Thomas M. Caswall, M.D.
	• Candidate Selection — John M. Hamilton, M.D.
	• Candidate Support — R. Benjamin Moore, M.D.
	• Coordination with Other Organizations — Francis C. Coleman, M.D.
	• Auxiliary Involvement — Mrs. B. David Epstein (Edie)
4:30 p.m.	Question and Answer Period
5:00 p.m.	Adjournment



Correspondence

GOOD TIDINGS FOR PHYSICAL FITNESS ISSUE

To the Editor: The Navy Department is embarking on a program of increased emphasis on physical fitness for active duty personnel. This is part of an effort by all military departments to increase the stamina and fitness of our active duty members.

As the Navy physician representative to the Department of Defense, Physical Fitness Committee, I felt it was important to update my reference collection on the subject from the recent medical literature. In reviewing the *Medline* search, I was pleased to note the large number of professional articles on fitness that have been pub-

lished in *The Journal of the Florida Medical Association*.

My secretary called the association offices last Thursday in an attempt to secure a copy of *The Journal* for April 1980. I was surprised and more than pleased to have the copy arrive in Monday's mail. The professional content of *The Journal* will be shared with my professional peers in the other services and within the Navy.

Many thanks for your interest and prompt response.

D. E. Hoeffler, M.D., M.P.H.,
Captain, Marine Corps, United States Navy
Deputy Assistant Chief for Health Care
Programs
Washington, D.C.

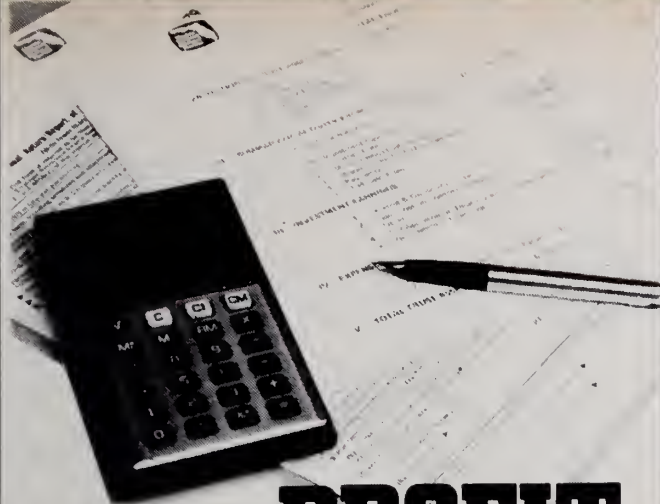


Corrections

The FMA Council and Committee Roster published in the July issue of *The Journal* incorrectly listed Charles B. Kahn, M.D., of Hollywood as having been elected as AMA Alternate Delegate for Seat #6 during the 107th Annual Meeting of the Florida Medical Association.

A correction should be made to this item (on page 586) showing that Charles J. Kahn, M.D., of Pensacola was elected to AMA Alternate Seat #6.

The August issue of *The Journal* erroneously carried notice of the death of Miguel Angel Cano, M.D. Dr. Cano, a former resident of Clewiston, now resides in the Miami area, and is engaged in family practice.



PROFIT FROM OUR EXPERIENCE

For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

We specialize in attaining the results that you require from your account in the areas of:

- **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.
- **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.
- **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

PEOPLE WHO KNOW HOW.

**Florida National
Trust Services**

214 Hogan Street
Jacksonville, Florida 32231
Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

TUTORIAL COURSES OF INSTRUCTION IN CORONARY CARE

Director: Louis Lemberg, M.D.
Co-Directors: Kyriacos Pefkaros, M.D.
Robert J. Myerburg, M.D.

SCHEDULE OF COURSES

1981

August 3-8
September 14-19
October 26-31
December 7-12

1982

January 18-23
February 15-20
March 8-13
March 29-April 3
June 14-19

(For more information please call (305) 325-6411 or complete coupon and mail to: M. Enriquez, Division of Cardiology (D-39), University of Miami School of Medicine, Post Office Box 016960, Miami, Florida 33101).

Please send me more information regarding
Tutorial Courses of Instruction in Coronary Care

Name _____

Phone () _____

Address _____

_____ Zip _____



Martin L. Schulkind, M.D. . . . has been appointed Chief of the Division of Rural Health in the Department of Community Health and Family Medicine at the University of Florida College of Medicine.

Dr. Schulkind is an Associate Professor of Community Health and Family Medicine and of Pediatrics. He directs the UF-affiliated clinics in Mayo and Trenton.

Vernon H. Bartley, M.D. . . . of Brandon, has been appointed an active member of the American College of Surgeons' Florida Committee on Trauma. Dr. Bartley, who recently relocated his practice to Brandon, held a similar position with the Chicago Committee on Trauma from 1972 to 1980.

Jacob Green, M.D., of Jacksonville . . . has been installed as President of the American Medical EEG Association. The national organization represents 700 Neurologists and Electroencephalographers.

The FMA Medical Education Committee . . . has accredited the continuing medical education programs of three Florida hospitals.

At its meeting in Tampa on August 7, the Committee granted provisional accreditation to Florida Hospital of Orlando for a two-year period beginning March 24, 1981 and ending March 23, 1983.

Reaccredited for six years each were Halifax Hospital Medical Center, Daytona Beach (to March 9, 1987) and Cedars of Lebanon Health Care Center, Miami (to March 9, 1987).

The national Accreditation Council for Continuing Medical Education has authorized the FMA committee to survey and accredit providers to certify certain CME offerings for American Medical Association Category I Credit.

The Medical Education Committee, headed by **Henry M. Yonge, M.D.**, Pensacola, was known until recently as the Committee on Continuing Medical Education. However, the "Continuing" was dropped to signify the Committee's interest in all levels of medical education.

Reaccredited for six years each were Halifax Hospital Medical Center, Daytona Beach (to March 9, 1987); and Cedars of Lebanon Health Care Center, Miami (to March 9, 1987).

Non - Medicare Patients to Make Up \$5 Million Hospital Loss

Florida hospital patients not covered by Medicare will pay approximately \$5 million more each year because of a change in the way the Federal Government reimburses hospitals, according to Florida Hospital Association health economist Ken McGee.

Recognizing that elderly patients require more care than other age groups, Medicare has provided hospitals

an 8½% nursing differential in the formula used to reimburse hospitals. The new federal budget reduces the nursing differential to 5 percent.

Half of the hospital patients in Florida are non-Medicare patients and they will have to make up the \$5 million loss in the form of higher hospital charges or reduced nursing care, McGee said.

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate[®] Dospan[®] ^{IV} (diethylpropion hydrochloride USP)

75 mg controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

Merrell Dow

*Registered Trademarks of MERRELL-NATIONAL LABORATORIES Inc., Cayey, Puerto Rico 00633

References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York. Raven Press, 1978, pp. 391-404.

Tenuate[®] ^{IV}
(diethylpropion hydrochloride USP)

Tenuate Dospan[®] ^{IV}
(diethylpropion hydrochloride USP)

controlled-release
AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine[®]) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

Licensee of Merrell[®]
MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:



MERRELL DOW PHARMACEUTICALS INC
Subsidiary of The Dow Chemical Company
Cincinnati, OH 45215, U.S.A.

Merrell Dow



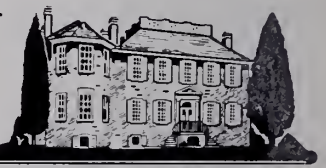
"I told him to get help for his drinking. He told me to go to hell."

Too often, the hardest part of treating alcoholism is persuading patients to seek help. Many patients refuse because they think their problem is "just a little one."

Fenwick Hall has the staff, the facilities and the compassion to treat any stage of alcohol or drug addiction. Our 4 to 6 week specialized program incorporates medical detoxification and counseling with a unique Family Program, comprehensive After Care and the tenets of AA to enhance self-growth and recovery without sacrificing dignity.

If one of your patients has a problem with alcohol or drugs, you need to know about Fenwick Hall.

JCAH ACCREDITED. BLUE CROSS/CHAMPUS PROVIDER.
MOST PRIVATE INSURANCE ACCEPTED.



FENWICK HALL

John H. Magill, Executive Director
P.O. Box 688, Johns Island, South Carolina 29455 (803) 559-2461

Medical
Decorators

NEW OR EXISTING SPACE
PROFESSIONALS WORKING
AROUND YOUR SCHEDULE

(305) 772-0090
By Appointment

CARY MARTIN
5055 N.E. 13 Ave.
Fort Lauderdale, Fla. 33334



FMA AUXILIARY

FMAA News Capsules . . .

Auxiliary Leaders from across the state led by FMAA President Mrs. Frank Coleman gathered at the Host International Hotel in Tampa September 16-18 for the annual FMAA Fall Conference and Board Meeting.

The group met for three days to formulate policies, define programs, and report on ongoing community projects. The state medical auxiliary, and its component county members, raise funds for the AMA-ERF, INTERPLAST (a non-profit organization offering free reconstructive surgery to international children deformed by accidents and birth defects), and the Florida Migrant Workers through their agencies. It also offers scholarships to students of health careers. It supports the Impaired Physicians Program, and, through its Legislation Committee, operates a LegsAlert System which works closely with FMA and FLAMPAC. It has a program on Child Abuse, and, this year, a working committee on Aging.

The conference was also a time to exchange ideas, to share and learn. A special teaching seminar was held on *Editing, Writing For and Layouting*, and *Producing the Mechanicals* of a newsletter, with *FMA Journal* Editor **Dr. Daniel Nunn**, FMA Regional Manager **Douglas Guetzloe**, and Advertising and Publishing Executive **William Burridge** as resource persons and lecturers. FMA Communications Director **Samuel D. Flowers** gave pointers on *PR and Publicity*; Speech and Communications Professor **John Sisco, Ph.D.**, gave tips on *How to Run Effective Meetings*; Management and Planning expert **Albert Wellner** talked about *Long Range Planning*; representatives from the FMA staff discussed *Basic Legislation*; and "professional volunteer" **Lynn Wellner** dwelled on the *Productive Leadership of Volunteers*.

"*Medical Marriages are Different — Fact or Fiction?*", "*Understanding Misunderstanding*", "*Experiencing and Understanding Aging*", "*Managing the Many Decisions of the Super Squeeze*" — these were the intriguing topics explored by other noted speakers invited by the medical spouses to highlight their three-day meet-

ing. They were TV Producer/Columnist/Author **Ruth Ann Fowler**; Medical Communications Professor **David Smith, Ph.D.**; **Joan Petrany**, a psychiatric nurse and a doctor's wife; and Gerontology Consultant **Jean Ware Smith**.



Mrs. Arnold Spanjers

Bernadine (Bennie) Spanjers is an auxilian in the news! A past president of the FMAA and the Polk County Medical Association Auxiliary, she has just been named by **Governor Bob Graham** to the State Ethics Commission.

The first Republican ever elected to office in Polk County since Reconstruction days, Mrs. Spanjers carries very impressive credentials.

A registered lobbyist, she was chairman for the Florida School Board Association, the National School Board Association, and the Federal Relations Network. Bennie was on the Polk County School Board for four years, served on the state migrant educational task force, chaired PRIDE (a parental drug program), and is the 1981 Campaign Chairman of the United Way of Central Florida. She is involved with the Provisionals of the Greater Winter Haven Junior Service League, the Winter Haven Hospital Foundation, and is the legislative chairman for the State Affairs Task Force of the Winter Haven

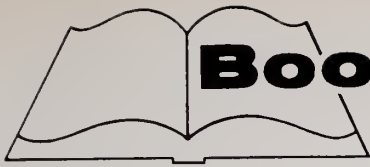
Chamber of Commerce. Believing that "people need people, and they need to get involved", Mrs. Spanjers served as liaison from her congressional district to Congressman Ireland and spokesman for the Florida delegation to Senators Chiles and Stone. Beyond these, the list is still long!

Bennie is married to **Dr. Arnold Spanjers**, a radiologist from Winter Haven. They have three grown children — an ER physician, an attorney, and a second year medical student.

This is the **International year of the Disabled**. The AMA Auxiliary Project Bank, with headquarters at 535 N. Dearborn St., Chicago, IL 60610, has several projects for handicapped people:

- the Talking Books Project (8-HS-3-5) in which the Auxiliary helps supply visually handicapped people with free tape recorders and tapes of books and periodicals;
- the Activity Center Project (8-HS-3-6) which offers handicapped persons from 16 to 60 years old basic adult education, craft classes, and field trips;
- the Sponsorship Project (8-HS-3-7) which outlines how Auxiliary sponsored children are in need of therapy.

Resource tools such as films, brochures, and booklets dealing with rehabilitation issues and social attitudes toward the disabled can be obtained free of charge from the President's Committee on Employment of the Handicapped, 1111 20th Street N.W., 6th Floor, Washington, D.C. 20026.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

George Orwell, *A Life*, by Bernard Crick. 473 Pages. Price \$17.95. Little, Brown and Company, Boston, 1980.

Bernard Crick, Professor of Politics at Birkbeck, University of London, calls George Orwell the finest political writer in English since Jonathan Swift. As such, Orwell deserves our closer attention.

George Orwell is perhaps best remembered in America for his two books *1984* and *Animal Farm*. However, he began his writing career as a novelist and was planning one when he died. Orwell was an essayist of the first order. Frequent themes were love of nature, love of books and literature, dislike of mass production, distrust of intellectuals and suspicion of government. Other themes were praise of plain language, plain speaking and patriotism. Crick feels that Orwell's *1984* is to 20th century ills what Hobbes' *Leviathan* was to the 17th century.

Christened Eric Blair, Orwell was born in India. His father was a civil servant 18 years older than Orwell's mother. Orwell was brought back to England in early childhood where he and his sister could be raised "properly." He was educated in private schools, barely affordable by his father. He attended Eton from age 14 to 18. Orwell wrote later, "At the age of 17 or 18, I was both a snob and a revolutionary. I was against all authority. I had read and re-read the entire published works of Shaw, Wells and Galsworthy, at that time still regarded as 'dangerously advanced' writers; and I loosely described myself as a Socialist." He was unable to attend Oxford because no scholarship was available.

Orwell joined the British Foreign Service and served in Burma from 1922 to 1927. During this period of time, he was able to get some insights which he later developed in his political writing. One was, "When the white man turns tyrant it is his own freedom that he destroys." Another was, "Once leaders are laughed at, their authority is gone." He subsequently left the Foreign Service in order to pursue a career in writing. It was at this time he affected the name George Orwell.

Never a communist, he sold the family silver to equip himself to fight on the side of the communists during the Spanish Civil War. There he became disgusted with the disorganization and selfishness which he saw as well as the cruelty on both sides. He received a bullet wound in

the neck but survived only to reach home a disillusioned man.

According to Crick, Orwell saw himself as a violent unmasker of published pretentiousness, hypocrisy and self-deceit, telling people what they did not want to hear; but in private he was a gentle and tolerant man.

Having recently come from the war in Spain, Orwell was against England's entry into the war against the Nazis. However, his patriotism overcame his personal aversion to war. He was not able to enter the military because of his previous neck wound and a lung condition which later turned out to be tuberculosis. From 1941 to 1943, he was broadcasting with the BBC.

Animal Farm was written from 1943 to 1945. This animal allegory refers to Stalinist communism. Unable to find a publisher in England because of the sensitive political situation, *Animal Farm* was first published in the United States. This was the first commercial success for Orwell's writings. Orwell stated in his preface to *Animal Farm*, "Liberty is the right to tell people what they do not want to hear."

In one of his essays Orwell stated, "Few thinking people now believe in life after death . . . the real problem is how to restore the religious attitude while accepting death as final. Men can only be happy when they do not assume that the object of life is happiness."

With the publication of *1984* in 1948, Orwell's literary and commercial success was assured. However, by this time his tuberculosis advanced to such a degree that most of his time was spent in tuberculosis sanatoria. Having previously had a reaction to streptomycin, the drug was discontinued. However, when his clinical situation deteriorated, it was decided by his doctors to try streptomycin again. A beautiful clinical description of his streptomycin reaction was recorded by Orwell. During this time, near death, Orwell in an essay entitled, "Lear Tolstoy and the Fool" stated, "A normal human being does not want the kingdom of Heaven: he wants life on earth to continue. This is not merely because he is 'weak', 'sinful' and anxious for a 'good time.' Most people get a fair amount of fun out of their lives but on balance life is suffering, and only the very young or the very foolish imagine otherwise."

The book made me wish to read more of Orwell's

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

**Each CEREBRO-NICIN® capsule
contains:**

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



essays. Orwell deserves to be esteemed for his clear, concise writing.

F.N.V.

The Complete New Guide to Preparing Baby Food
by Sue Castle. 336 Pages. Price \$13.95. Doubleday, New York, 1981.

This book is a comprehensive venture into the world of infant and toddler feeding, nutrition and food information in general. It covers the area of nutrition extensively, reviewing all the essential elements of a good dietary regime for children.

There is a chapter on feeding from breast milk to finger foods with all the ensuing problems, colic, diarrhea and spitting up.

Approximately 180 pages are devoted to recipes, food preparation and information about specific foods to serve the baby.

There is a short chapter on appliances helpful in food preparation.

This is a publication I would highly recommend to new mothers. It is the most thorough guide to infant and child feeding that I have ever come across. This book would make a wonderful baby gift and would be a worthy addition to any pediatrician's reference library.

*Audrey L. Schiebler
Gainesville*

Mrs. Schiebler is the mother of six children. She is Circuit Coordinator, State of Florida, Guardian Ad Litem Program, Eighth Judicial District. She is also chairman of the building committee of the Ronald MacDonald House for the Gainesville region. She remains a close friend of the former editor of the JFMA.

Diseases of the Liver and Biliary System, Sixth Edition, by Dame Sheila Shearlock. 537 Pages. Price \$67.50. Blackwell Mosby Book Distributors, St. Louis, MO, 1981.

This now classic text on liver disease, first published in 1955, is presently in its sixth edition. The printing, illustrations, radiographs and photomicrographs are particularly well done. In the section on hepatic tumours, for example, beside the arteriograms are line drawings with explanations and labels, making their interpretation somewhat easier for the non-radiologist. The chapter on the immunology of liver disease is clear, concise and up-to-date. This text, while not as encyclopedic as some, deserves a place on the shelf of those physicians interested in the treatment of liver disease.

F.N.V.

Review of Medical Physiology, 10th Edition, by W.F. Ganong. 628 Pages. Price \$17.00. Lange Medical Publications, Los Altos, CA, 1981. Paperback.

This soft cover book now in its 10th edition, contains eight sections and forty chapters. Pertinent references are given at the end of each section. For a book of this kind, it is complete and up-to-date. The medical student and physician wishing to use a less-than encyclopedic review of physiology will find this book useful.

F.N.V.

Doctors' Wives: The Truth About Medical Marriages, by Cynthia S. Smith. 215 Pages. Price \$11.95. Seaview Books, New York, 1980.

Biased statements, poorly documented statistics and distorted analyses litter the pages of *Doctors' Wives: The Truth About Medical Marriages* by Cynthia Smith, the editor of *Medical/Mrs.* This magazine is geared to physicians' wives and usually includes one or more articles that deal with various stress factors which may be encountered in a medical marriage. It sometimes happens that when one becomes concerned in a particular area for a length of time, one begins to generalize. It seems this may be what happened to Ms. Smith, who began to see almost all medical marriages as legal and/or emotional failures with the wife always cast as the victim. The result was this book . . . but who would be the audience? Perhaps the author thought that it would appeal to a general public who is supposedly fascinated by anything written about doctors and their private lives. Based on the premise that most physicians' wives are ineffectual, dependent, simple and shallow, the book then portrays the doctor as a mercenary, sexually ineffectual, unfaithful, provincial individual.

Doctors' Wives seems to have little literary value. It is not particularly entertaining, it is not factual nor is it statistically sound since there is very little valid data available to support the views expressed in this book.

Suzanne Cohan
Pensacola

Mrs. Cohan has seen medical marriage both from the point of view of growing up in a medical home, her father is a psychiatrist, and from the point of a medical wife. Her husband, Robert, is a pediatrician-allergist. She is an instructor in behavioral sciences at Pensacola Jr. College and is a previous contributor to the book review section. Her more detailed review of this book, previously published in the Escambia County Medical Society Bulletin, is available on request from the JFMA Book Review Section.

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



**REINSURANCE
BROKERS for
Florida Physicians
Insurance Reciprocal
—serving physicians
throughout Florida**



**The
Wetzel
Company,
Inc.**

P.O. Box 66452 • Houston, Texas 77006

Second Annual
“INTERAMERICAN MEDICAL SYMPOSIUM”
“Cardio-Pulmonary, Renal and Hypertensive Disorders”

Sheraton Bal Harbour Hotel
December 13 - 17, 1981
Bal Harbour, Florida

In this Second Annual Interamerican Medical Symposium a distinguished **faculty from North, Central and South America** will review cardiopulmonary, renal and hypertensive diseases with special emphasis on the geographic characteristics and most recent modes of therapies. **Interdisciplinary Symposia** with open discussions will be the basic format. All presentations will be offered in **English and Spanish with simultaneous translation.**

CARDIOVASCULAR DISEASES

- Ambulatory Monitoring of Arrhythmias
- Coronary Artery Disease
- Diagnosis of Coronary Spasm
- New Techniques in Nuclear Cardiology
- Stress Tests
- Sudden Death — Pacemakers
- Surgery of Valvulopathies
- Vasodilators and Beta Blockers

HYPERTENSIVE DISEASES

- Adrenal Hypertension
- Cardiovascular Risks
- Complications of Drug Therapy
- Essential Hypertension
- New Antihypertensive Drugs
- Radiological Diagnosis of Hypertension
- Secondary Hypertensive States
- Work-up of the Hypertensive Patient

PULMONARY DISEASES

- Extrinsic Allergic Alveolitis
- Interstitial Pneumopathies
- Pulmonary Hypertension
- Pulmonary Thromboembolism
- Respiratory Insufficiency
- Reversible Airway Obstruction Syndromes
- Sleep-Apnea Syndromes
- Tuberculosis, Prophylaxis & Chemotherapy

RENAL DISEASES

- Acute Renal Failure
- Ambulatory Peritoneal Dialysis
- Glomerulopathies
- Lupus Nephropathy
- Nephrolithiasis
- Newer Renal Therapies
- Plasmapheresis
- Renal Osteodystrophy

24 credit hours in Category I of the Physician's Recognition Award of the American Medical Association and Mandatory Hours of the Florida Medical Association.

Registration Fee: \$200 before October 30, 1981 — \$250 after October 30, 1981

For registration and information write to: Jose S. Bocles, M.D., University of Miami, Department of Medicine (R-760), P.O. Box 016760, Miami, Florida 33101, U.S.A. Phone: (305) 547-6063

MEETINGS

Accepted by the FMA Committee on Medical Education for Mandatory Credit

NOVEMBER

Clinical and Electrophysiological Appraisal of Signs of Radicular Injuries in Back Pain, Nov. 2, Jess Parrish Memorial Hospital, Titusville. For information: Richard Barr, M.D., JPMH, Titusville 32780.

Selected Topics in Cardiology, Nov. 4-6, Wolfson Auditorium, Miami Beach. For information: Philip Samet, M.D., 4100 Alton Road, Miami Beach 33140.

5th Annual Medical Aspects of Aging, Nov. 5-7, Gainesville Hilton, Gainesville. For information: Office of CME, University of Florida.

Clinical Management of Coronary Disease and Exercise Testing, Nov. 6-8, Orlando Hyatt, Orlando. For information: Stephen E. Mattingly, 64 Inverness Drive East, Englewood, CO 80112.

Southeastern Section, Postgraduate Seminar, Nov. 6-8, Sheraton Bal Harbour Hotel, Bal Harbour. For information: Victor A. Politano, M.D., Southeastern Section, Postgraduate Seminar, 6614 Miami Lakes Drive, East, Miami Lakes 33014.

Conferences in General and Family Practice, Nov. 9, International Hospital, Miami, Florida. For information: Alfredo Crucet, M.D., and Heather Childs, ARNP, Dept. of Family Medicine, P.O. Box 016700, Miami, Florida 33101.

Conferences in General Medicine and Family Practice, Nov. 11, International Medical Center, Miami. For information: Alfredo Crucet, M.D. and Heather Childs, Dept. of Family Medicine, University of Miami, P.O. Box 016700, Miami 33101.

Management of the Arthritides: 1981, Nov. 12-14, Ponce de Leon Motor Hotel, St. Augustine. For information: Louis M. Sales, M.D., 1204 LeBaron Avenue, Jacksonville 32207.

Current Advances in Perinatology, Nov. 15-21, St. Thomas, Virgin Islands. For information: Charles Bauer, M.D., Univ. of Miami School of Medicine, Dept. of Pediatrics, P.O. Box 016960, Miami 33101.

14th Family Practice Review, Nov. 16-20, Hotel Royal Plaza, Lake Buena Vista. For information: Lamar Crevasse, M.D., Box J-233, JHM Health Center, Gainesville 32610.

The ABC's of Viral Hepatitis, Nov. 19, Ft. Cooper Station Restaurant, Inverness. For information: C. J. McGrew Jr., M.D. 2875 Keyville Avenue, Spring Hill 33526.

Childhood Cancer — The Challenge of Survival, Nov. 19-21, Sheraton Sand Key Hotel, Clearwater Beach. For information: Deborah A. Hurwitz, MSW, Florida Association of Pediatric Tumor Programs, P.O. Box 13372, University Station, Gainesville 32604.

Advanced Epidemiology, Nov. 20-21, Miami, Florida. For information: Janet Konefal, Dept. of Epidemiology and Public Health, P.O. Box 016960, Miami 33101.

Multiple Sclerosis Update for Physicians in Practice, Nov. 20-23, Walt Disney World Conference Center, Lake Buena Vista. For information: Allen D. Roses, M.D., Professor and Chief, Division of Neurology, Duke University Medical Center, Durham, N.C. 27710.

8th Annual Meeting — Peruvian American Medical Association and University of Miami School of Medicine, Nov. 24-28, Bal Harbour. For information: Dr. Hernan Carrion, Dept. of Urology, P.O. Box 016960, Miami 33101.

Emergencies in Internal Medicine V, Critical Decision Making in Patient Management, Nov. 30-Dec. 4, Condado Holiday Inn Resort, San Juan, Puerto Rico. For information: Division of CME D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

DECEMBER

Primera Conferencia Latinoamericana en Oncologia (in Spanish), Dec. 1-5, Bal Harbour. For information: Peter Mansell, M.D., Dept. of Oncology/Comprehensive Cancer Center, P.O. Box 016960, Miami 33101.

The 1981 Neuro-Ophthalmology Course, Dec. 3-5, Miami. For information: Gaby Kressly, Dept. of Ophthalmology/Bascom Palmer Eye Institute, P.O. Box 016960, Miami 33101.

Ultrasound as Used in Modern OB-GYN, Dec. 6-10, Miami. For information: Dr. William Little, Dept. of OB-GYN, P.O. Box 016960, Miami 33101.

American Cancer Society — National Conference Gastrointestinal Cancer, 1981, Dec. 8-10, Fontainebleau Hilton Hotel, Miami Beach. For information: Nicholas G. Bottiglieri, M.D., American Cancer Society, National Conference, Gastrointestinal Cancer, 1981, 777 Third Avenue, New York, New York 10017.

Advanced Epidemiology, Dec. 11-12, Miami. For information: Janet Konefal, Dept. of Epidemiology and Public Health, P.O. Box 016960, Miami 33101.

2nd Annual Interamerican Medical Symposium (in English/Spanish), Dec. 13-17, Bal Harbour. For information: Jose Bocles, M.D., Department of Medicine, P.O. Box 016960, Miami 33101.

Conferences in General Medicine and Family Medicine, Dec. 14, International Hospital, Miami. For information: Alfredo Crucet, M.D. and Heather Childs, Dept. of Family Medicine, P.O. Box 0167001, Miami 33101.

The Fourth Winter Seminar-Medicine for Tomorrow, Dec. 20-Jan 3, Aspen, Colorado. For information: DCMA, 1501 N.W. North River Drive, Miami 33125.

JANUARY

Arthroscopic Update Emphasizing Problem-Solving in Therapeutic Arthroscopy of the Knee, Jan. 10-14, Sandpiper Bay, Port St. Lucie. For information: Ronald S. Grober, M.D., 2000 Nebraska Avenue, Ft. Pierce 33450.

5th Annual Oral Pathology Review, Jan. 11-15, Miami. For informa-

tion: Gloria Allington, Dept. of CME, P.O. Box 016960, Miami 33101.

27th Annual Cardiovascular Seminar, Jan. 15-16, Holiday Inn Surfside, Clearwater Beach. For information: Mr. E. Jerry Eatman, American Heart Association, P.O. Box 7188, St. Petersburg 33734.

Principles of Practice Management, Jan. 23-30, Vail, Colorado. For information: Sonja Auxier, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101.

Symposium on Intensive Care, Jan. 23-31, Vail, Colorado. For information: Sonja Auxier, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101.

7th Annual Review and Recent Practical Advances in Pathology, Jan. 25-29, Bal Harbour. For information: Dr. Sharon Thomsen, Dept. of Pathology, P.O. Box 016960, Miami 33101.

8th Annual Vail Conference in Anesthesiology, Jan 30-Feb. 5, Vail, Colorado. For information: Sonja Auxier, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101.

Pediatric Nephrology IX, Jan. 31-Feb. 4, Bal Harbour. For information: Jose Strauss, M.D., Dept. of Pediatrics, P.O. Box 016960, Miami 33101.

When
Impotence
is due to androgenic deficiency.

Android[®] 5^{mg} / 10^{mg} / 25^{mg}
Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

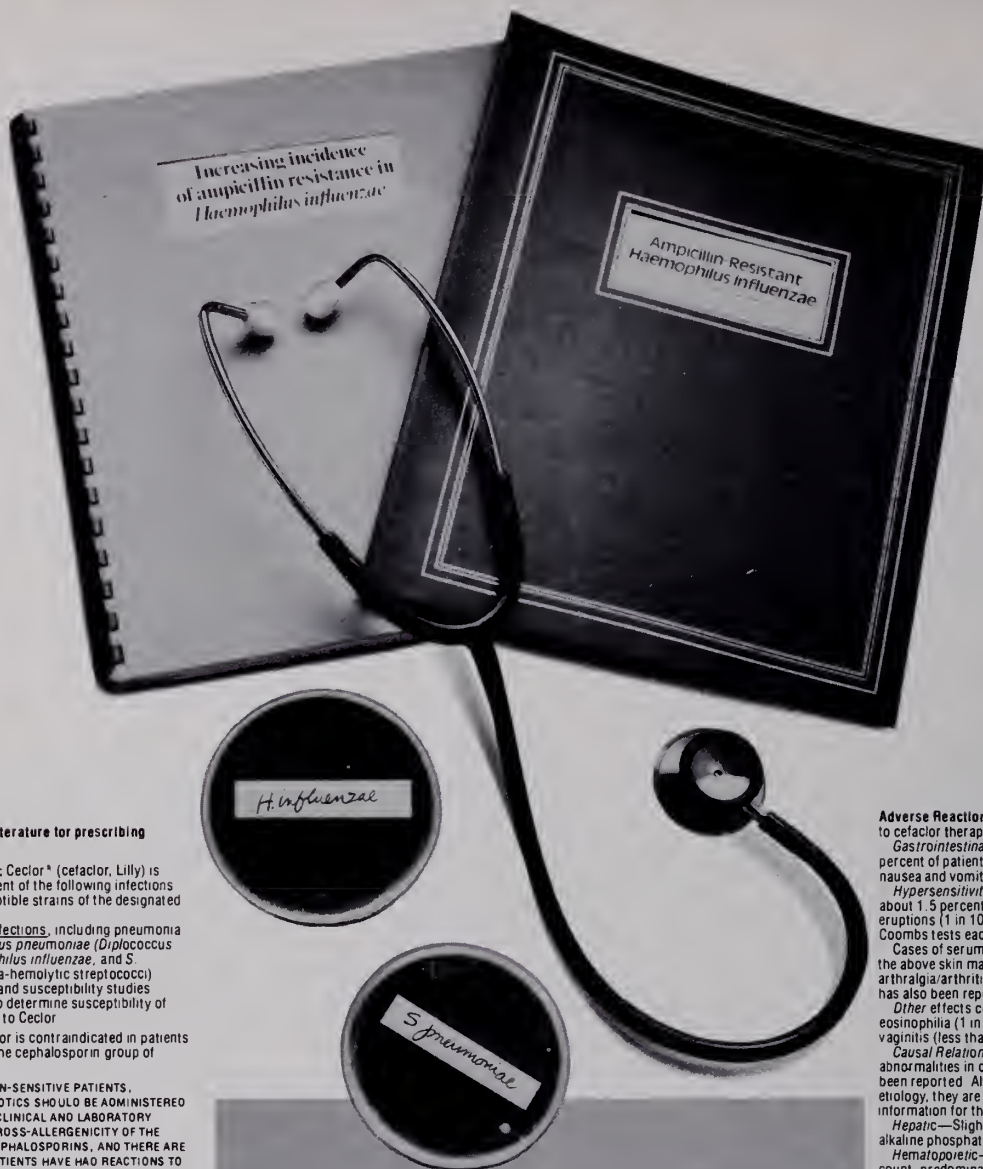
Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female. *Clinimedic Drug Therapy*, Sept. 1976. **SUPPLIES:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

Write for new double blind study reprints and samples.

THE BROWN PHARMACEUTICAL CO., INC.
2500 West 30th Street, Los Angeles, California 90067

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Cefaclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindication: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

Cefaclor®

cefaclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(1030808)

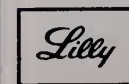
* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), 11:880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1977.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

100061

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

MEDICAL OPHTHALMOLOGIST wanted for busy practice. No refraction or contact lens fitting. Ideal location in East Coast of Florida. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

FAMILY PRACTITIONER OR INTERNIST needed to join staff of a Family Medical Center in North Florida. Excellent opportunity for professional and economic growth. Respond with CV to: Susan Masterson, Emergency Medical Services Associates, Inc., 8200 W. Sunrise Blvd., Building C, Plantation, Florida 33322, or phone (800) 327-0413. In Florida call (305) 472-6922.

FLORIDA — Aggressive group, fee-for-service, malpractice, group health insurance, teaching, EMS, opportunity for advancement. Contact Steve Watsky, M.D., 707 40th Street West, Palmetto, Florida 33561, (813) 722-1722 or P. Fagan Jr., M.D., Post Office Box 9639-FL, Marina Del Rey, California 90291, (213) 822-1312.

PSYCHIATRIST OPENINGS at Northeast Florida State Hospital near Jacksonville. Position as Service Center Directors, as Staff Psychiatrists, and also as physicians are now available. Assignments on General Adult Psychiatric Service, Geriatric Service, and Children's Service as well. Competitive salary and benefits. Affiliation with the University of Florida, Gainesville, EEO/AA. Please contact Clinical Director, Northeast Florida State Hospital, Hwy. 121, S., Macclenny, Florida 32063 or call (904) 259-6211, ext. 110.

COMPHEALTH - LOCUM TENENS

— Physicians covering physicians, nationwide, all specialties. We provide cost effective quality care. Call us day or night. T.C. Kolff, M.D., President, Comphealth, 175 West 200 South, Salt Lake City, Utah 84101, (801) 532-1200.

PHYSICIANS WANTED: non-clinical disability evaluation medical consultation for Social Security. Full time, 40 hour work week. Knowledge of electrocardiographic interpretation desirable. Write or call G. M. Davis, State Medical Consultant, 3437 Lawton Road, Suite 127, Orlando, Florida 32803; (305) 896-4691.

EMERGENCY DEPARTMENT PHYSICIAN needed to join established group in North Central Florida. Paid malpractice, profit sharing and pension plan second year. 28 hour work week. Good salary first year. Contact R. W. Carr, M.D., 9900 N.W. 115 Avenue, Ocala, Florida 32671.

LOCUM TENENS in Diagnostic Radiology with Ultrasound capabilities. Two week minimum. Florida license required. -ABR certified or eligible. Send C.V. with inquiry to Drs. Plenge and Bedoya, 600 North Church Street, Lake City, Florida 32055, or call collect after hours (904) 755-2235.

OBSTETRICIAN / GYNECOLOGIST — South Central Florida — Excellent solo opportunity with good coverage for OB/GYN with Florida license in community of 25,000 with a service area population of 50,000. New 75 bed, full service hospital. Office space available in new professional building next to hospital. Area unsurpassed in natural beauty and recreational activities. Extremely high earnings potential. Send C.V. to Jim Butler; Manager, Medical Relations, Hospital Corp. of America, One Park Plaza, Nashville, Tennessee 37203, or call toll free (800) 251-2561.

RAPIDLY GROWING 23 man multi-specialty group on Florida's Treasure Coast, will add a well trained Family Practitioner to its five man Family Practice Department. Please send C.V. to C-1065, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIANS WANTED! Non-clinical disability evaluation medical consultation for Social Security. Fulltime 40 hour work week. Knowledge of electrocardiographic interpretation desirable. Write or call Dr. George Davis, State Medical Consultant, 3438 Lawton Road, Suite 127, Orlando, Florida 32803. Phone (305) 896-4691.

EMERGENCY MEDICINE: Clinical and Directorship positions available in moderate volume emergency department located in Brooksville. Excellent income, flexible scheduling without on-call duty, and paid malpractice insurance. For details, send credentials in confidence to Susan Haberman, 1111 N. Westshore Blvd., Suite 211, Tampa, Florida 33607; or call collect (813) 870-2356.

FLORIDA - GENERAL INTERNIST/ MEDICAL DIRECTOR for private non-profit primary care facility. 75% Clinical; 25% administrative. Full-time position. Administrative experience required. Able to achieve hospital privileges. Contact: Executive Director, Mid-County Medical Center, 8190 Okeechobee Blvd., West Palm Beach, Florida 33411. (305) 684-1119.

WANTED: NON-INVASIVE CARDIOLOGIST to join well established high caliber internal medicine group in Florida. Private practice affiliated with excellent hospital with stress, nuclear and echo. Lucrative. Delightful location. Contact: C-1068, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN or Family Practitioner wanted. No Obstetrics or emergency room involved. Five-day work week with occasional weekend call. Contact: Albert R. Folds, M.D., P.O. Box 728, Marianna, Florida 32446 — or call (weekdays) (904) 526-2123, ext. 300.

INTERNIST / Board Certified or Board Eligible. Group of 16 Board Certified Internists, several subspecialty certified, seek association with a Board Certified or Board Eligible Internist. Excellent academic stimulus; financial security with progressive incentive. No investment necessary. Beautiful area of Palm Beach, Florida. Please send CV to Leonard W. Appleby, M.D., The Lake Worth Medical Center, 518 N. Federal Highway, Lake Worth, Florida 33460.

EXPANDING 16 Member Multi-Specialty Clinic Openings. Rheumatologist, Nephrologist, and Thoracic and Vascular Surgeon. Must be Board Certified or Board Eligible. Guaranteed salary with incentive. Clinic located in the heart of Florida citrus industry and lake country. One and a half hours to either coast. Immediate drawing area 90,000. For additional information send CV to C-1069, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST — CARDIOLOGIST: Three man practice seeks badly needed associate with immediate availability possible. Excellent opportunity in well established Internal Medicine, non-invasive Cardiology practice in Coral Gables, Florida. Reply C-1036, P.O. Box 2411, Jacksonville, Florida 32203.

ANESTHESIOLOGY — Director required by licensed Ambulatory Surgical Center. Contract terms commensurate with credentials. Excellent benefit package including option to participate in ownership. Send resume, three references, and salary requirements to AMI, 1661 Phillips Road, Tallahassee, Florida 32308.

PEDIATRICIAN — BC/BE to join an active and growing primary care practice. Initially to share office and call. Office is next to Flagler Hospital. Financial arrangements negotiable. Florida license required. Write or call Robert K. Wise, M.D., 11 Tremerton Street, St. Augustine, Florida 32084. Phone (904) 829-6591.

ANESTHESIOLOGIST needed for 174 bed, all private hospital. No emer-

gency, nor OB, 4 OR's. Fee for service. Top remuneration. Call: R. Martorell, M.D., Memorial Hospital, 2901 Swann Ave., Tampa, Florida 33609. (813) 877-0441.

FAMILY PHYSICIAN needed for solo or group type practice. Fee for services and guaranteed referrals. Brand new and well equipped office building. Located on one of Florida's finest Gulf and sun coast communities. Center for cultural, educational and recreational resources. Good opportunity for right person. For more information contact: Post Office Box 834, Bradenton, Florida 33506.

FAMILY PHYSICIAN to join 2-man family practice next door to 300 bed hospital. Excellent privileges. Salary guaranteed with fringes and incentives. Partnership at end of 2nd year. Contact E.P. Dickerson, M.D., Westside Family Physicians, Suite 5500, 2010 59th Street, West Bradenton, Florida 33505. (813) 792-2211.

Situations Wanted

GENERAL, COLON AND RECTUM SURGEON, trained in Colonoscopy, Board eligible, 35, seeks position in Florida to practice either one specialty or both. Speaks Spanish fluently. Available October 1981. Contact: Luis F. Espallat, M.D., 1517 Texas Avenue, Homestead AFB, Florida 33039. Phone (305) 257-2870.

BOARD CERTIFIED FAMILY PRACTITIONER; Board Eligible ER; clean record; 23 years experience desires full or part time salary position in clinic, ER, or teaching in Central or N.E. Florida. Write C-1064, P.O. Box 2411, Jacksonville, Florida 32203.

31 YEAR OLD BOARD CERTIFIED; well trained in all aspects of Dermatology, and Dermatologic Surgery. Looking for a full or part time position in Florida. Reply: Jack Albert, M.D., P.O. Box JJ, Big Stone Gap, Virginia 24219. (703) 523-2000 (10:00 - 4:00 work), (703) 523-3258 (home). Available after November 1, 1981.

BOARD CERTIFIED (FAMILY MEDICINE) Florida license. Seeks 40 hour a week job in private clinics, public health or nursing homes, also Locum Tenens. Reply: C. C. Barrameda, M.D., 333 N.E. Surrey Street, Port St. Lucie, Florida 33452. Telephone: (305) 878-8834.

UROLOGIST, 31, American Graduate, Florida license, Board Eligible, excellent training at large New York City Medical Center. Desires group practice or partnership in South Florida. Phone: (212) 289-7235, evenings.

Practices Available

GENERAL PRACTICE for sale — growing area between Sanford and Longwood, Seminole County — Same location 10 years. Also possible association. Call Rose — (305) 862-8661.

BUSY INTERNAL MEDICINE practice available. Share initially with existing Internist then assume practice. (305) 659-4355.

ACTIVE GENERAL PRACTICE established for 11 years, for sale due to retirement. Well-equipped office, located close to Coral Reef General Hospital, Miami, Florida, will be available December 1981. Reasonable terms. Contact George J. Fiala, M.D., 9875 East Fern Street, Miami, Florida 33157. Telephone (305) 238-8561.

MIAMI BEACH GENERAL/INTERNAL MEDICINE Practice, long established. Lincoln Road. Available now, will introduce. Reasonable. (305) 334-2012.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

LAGO VISTA EXECUTIVE CENTER, 8019 N. Himes Avenue, Suite 300, Tampa, Florida 33614. 1,500 square feet, suitable for doctor. Quiet, pleasant atmosphere, overlooking landscaped lake. Convenient location. (813) 933-5100.

CONDOMINIUM for rent St. Thomas U.S.V.I. on the Caribbean, two bedrooms, two bathrooms, three pools, free tennis, reduced airfares. Still available for Perinatology meeting November 15th through the 21st. List of other meetings available. Call Dr. Blondy collect at (313) 478-2739.

COMPLETELY FURNISHED office 1,100 square feet, three exam rooms, EKG. Ideal for Internist, General Practitioner, Pediatrician, Surgeon. Present Internist relocating. (305) 659-4355.

FULLY EQUIPPED medical office with excellent equipment. Unlimited potential with new hospital. This is a golden opportunity in Florida's most rapidly growing area. Write P.O. Box 5668, Sun City Center, Florida 33570 or call (813) 634-3512.

FLORIDA BEACHFRONT HOME — Two BR, sundeck, fireplace. Ocean to Bay. Fish, sail. Explore coral reefs from private beach. North Vero Beach near Sebastian Inlet. Call p.m. (305) 361-1476.

MOUNTAINTOP, breathtaking view, Three BR, Three baths, pool, one or two acres. Asheville, N.C. Interest-free loan or cash discount. (813) 443-4077 or 596-0761. F. Stencil, 1270 Gulf Blvd., Clearwater, Florida 33515.

WESTERN NORTH CAROLINA BEAUTIFUL COUNTRY ESTATE — Listed in National Register of Historical Places. 4,000 square feet home completely restored and modernized. Two brick guest cottages. Caretaker home. Circular brick barn. 35 acres with several pastures, stream and pond. Additional acreage available. Ideal for combination practice/living or joint ownership arrangement. Magnificent setting near ski resort. \$375,000. Call owner for brochure. (704) 758-2279, 758-2458 or 758-2930.

PREFER PHYSICIAN besides G.P. to rent or lease space in new medical building in ideal location in Altamonte Springs, near hospital. 1,600 square feet with full facilities. Terms negotiable. Call collect (305) 331-7781; 886-5361.

SKIING: Winter wonderland, luxury chalet, 4 bedrooms, 4 baths, complete recreational level. Beech Mountain, North Carolina. Information and rates: P.O. Box 10064, Jacksonville, Florida 32207.

Art

FINE ART. Major paintings by

modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Co., 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Equipment

WE BUY, SELL, LEASE new and used medical instrumentation — EKG's, Laboratory, Holters, Scanners, Stress Test, Echocardiographs, etc. Contact: New Life Systems, Inc., Edgar Bentolila, P.O. Box 8767, Coral Springs, Florida 33065. Phone (305) 753-9961.

FOR SALE — Hamilton Power Examining Table — Excellent condition — slightly used. \$750. firm. Roy Kupsinel, M.D., Shangri-La Lane, P.O. Box 550, Oviedo, Florida 32765. (305) 365-6681.

Miscellaneous

32' ENDEAVOR SAILBOAT (1980) — Fully equipped plus many extras — RDF, VHF, CB, auto pilot and five man Avon dinghy, etc. Priced at 20% below

replacement. Physician owned and maintained. Financing available to right person. \$46,000. Call (904) 763-4838 or (812) 853-3847.

Meetings

SNOWMASS / VAIL "MEP" SKI SEMINAR on management Enrichment for the Health Professional. Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or Ski Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Seminars comply with IRS rules to make trip expenses deductible for doctor and spouse. For brochure and lodging information contact: M.E.P., An Education Corporation, 906 Cooper Ave., Glenwood Springs, Colorado 81601; or call (800) 525-3402.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

MICROSURGERY COURSES

The Microsurgery Laboratory at the University of Florida offers three and five day courses aimed at teaching techniques applicable to:

Extracranial to Intracranial Bypass
Digital Reimplantation
Tubal Reanastomosis
Vasovasostomy
Transsphenoidal Surgery
Temporal Bone Dissection
Other Microsurgical Operations

For Information write:

Mrs. Cindy Brady
Microsurgery Laboratory
Box J265
University of Florida Health Center
Gainesville, FL 32610

Advertisers

American Medical EEG Association Meeting	804	Eli Lilly & Company Cecilor	854
Boots Pharmaceuticals Ru-Tuss	810a	Merrell Dow Pharmaceuticals Tenuate	842a
Brown Pharmaceuticals Cerebro-Nicin	848	National Medical Enterprises Service	806
Lipo-Nicin	849	Smith Kline and French Dyazide	842a
Android	853	Roche Laboratories Valium	859
Burroughs Wellcome Zyloprim	805	Limbitrol	794
Cary Martin Decorating	844	Librax	842a
Convention Press Service	796	University of Florida Meeting	857
Fenwick Hall Service	846	University of Miami Meetings	841, 851
Florida Medical Foundation Citrus and Seafood	802	Werzel Service	850
Florida National Banks Service	841	Willingway Hospital Service	812
Florida Physicians' Insurance Reciprocal Service	798	Wyeth Laboratories Cyclapen-W	806
Geriatric Pharmaceutical Co. Cevi-Bid	801	Eguagesic	842a
Hospital Corporation of America Recruitment	812	Wygesic	842a
		Ativan Oral	802

Florida Medical Association Officers and Council Chairmen

Officers

Sanford A. Mullen, M.D., Jacksonville, President
 Robert E. Windom, M.D., Sarasota, President-Elect
 Gerold L. Schiebler, M.D., Gainesville, Vice President
 Luis M. Perez, M.D., Sanford, Secretary
 J. Russell Forlaw, M.D., Boynton Beach, Treasurer
 T. Byron Thames, M.D., Orlando, Immediate Past-President
 James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
 Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
 W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
 Louis C. Murray, M.D., Orlando, Legislation
 Charles P. Hayes, M.D., Jacksonville, Health Care Financing
 Joseph T. Ostroski, M.D., Miami, Medical Services
 Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
 Arthur L. Eberly, M.D., Lighthouse Point, Specialty Medicine

THE JOURNAL OF THE

NOVEMBER 1981 • VOL. 68 • NO. 11



FLORIDA MEDICAL ASSOCIATION

COUNTY

STATE

AMA

The
Federation
of Medicine

New
Commitments,
New
Challenges
for the 80s

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

DEC 9 - 1981

JOIN US:

**The only physician - owned,
medical society - sponsored
professional liability insurance
plan available to physicians in
Florida.**

- Sponsored and created by the Florida Medical Association.
- Reinsured by Lloyds' of London.
- Actuarially sound and nonassessable for future premiums.
- None of your premium is used to procure your business, i.e., no agents' commissions.

**FLORIDA
PHYSICIANS'
INSURANCE**

RECIPROCAL

1000 Riverside Ave. / P. O. Box 40198 / Jacksonville, FL 32203

Telephone (904) 354-5910 / Wats 1-800-342-8349



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

NOVEMBER 1981 • VOL 68 • NO. 11 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.
E. Charlton Prather, M.D.

Assistant Editors

Francis C. Coleman, M.D.
James K. Conn, M.D.
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
Norman M. Kenyon, M.D.
(from Board of Governors)
Edwãrd Pedrero Jr., M.D.

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Judie Hill Constantin

Consulting Editorial Staff

Fuad S. Ashkar, M.D.	Karl J. Kramer, M.D.
Thomas D. Bartley, M.D.	R. G. Lacsamana, M.D.
Robert L. Batey, M.D.	Richard F. Lockey, M.D.
Pierre J. Bouis Jr., M.D.	Philander D. Morgan, M.D.
Ms. Deborah B. Wilbur	George Morris, M.D.
William T. Branch, M.D.	George A. Nader Jr., M.D.
Miguel A. Brito, Jr.	Richard S. Panush, M.D.
Elmer B. Campbell, M.D.	R. A. Penalver, M.D.
Manuel L. Carbonell, M.D.	John K. Petrakis, M.D.
Ronald W. Case, M.D.	Phillip B. Phillips, M.D.
Toni Charneco	Michael R. Redmond, M.D.
Louis E. Cimino, M.D.	Albert L. Rhoton, M.D.
Charles Craig, M.D.	James F. Richards Jr., M.D.
R. Jay Cummings Jr., M.D.	Arvey I. Rogers, M.D.
Raul deVelasco, M.D.	William J. Romanos Jr., M.D.
James E. Deming	Lees M. Schadel, M.D.
Pablo Enriquez, M.D.	Frederick W. Schert, M.D.
Robert F. Feltman, M.D.	Guy T. Selander, M.D.
Richard Feinstein, M.D.	Roberto A. Sosa, M.D.
Lawrence M. Fishman, M.D.	John Stone, M.D.
Allan L. Goldman, M.D.	Robert H. Threlkel, M.D.
Henry L. Harrell, M.D.	Benjamin E. Victorica, M.D.
Allan Herskowitz, M.D.	Thomas M. Wiley, M.D.
James T. Howell, M.D.	Charles D. Williams, M.D.
Rubin Klein, M.D.	Frederic C. Wurtzel, M.D.

Subscription Rate: \$15.00 per year, single copy. \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917: authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

Scientific Articles

- 883 Calcium Channel Blockers:
Rationale For Their Clinical Use
C. Richard Conti, M.D.
- 887 Rationale and Methods of Splenic Preservation
Roger Sherman, M.D., FACS
- 890 Pure Red Cell Aplasia With Thymoma:
A Case Report and Brief Review of Pathogenesis
*Garnett R. Earlywine, M.D.,
and Fernando A. Rubio, M.D.*
- 895 Pessaries and Prolapse
Thomas A. Rodenberg, M.D.

Special Articles

- 899 The House of Medicine:
Focus on the American Medical Association
Charles Donegan, M.D.
- 902 Membership: It's a Question of Dollars and Sense
J. H. Sammons, M.D.

Editorials

- 873 The AMA: The Medical House of Glass
Edward Pedrero, Jr., M.D.
- 875 AMPAC Celebrates Its 20th Birthday
F. C. Coleman, M.D.

Departments

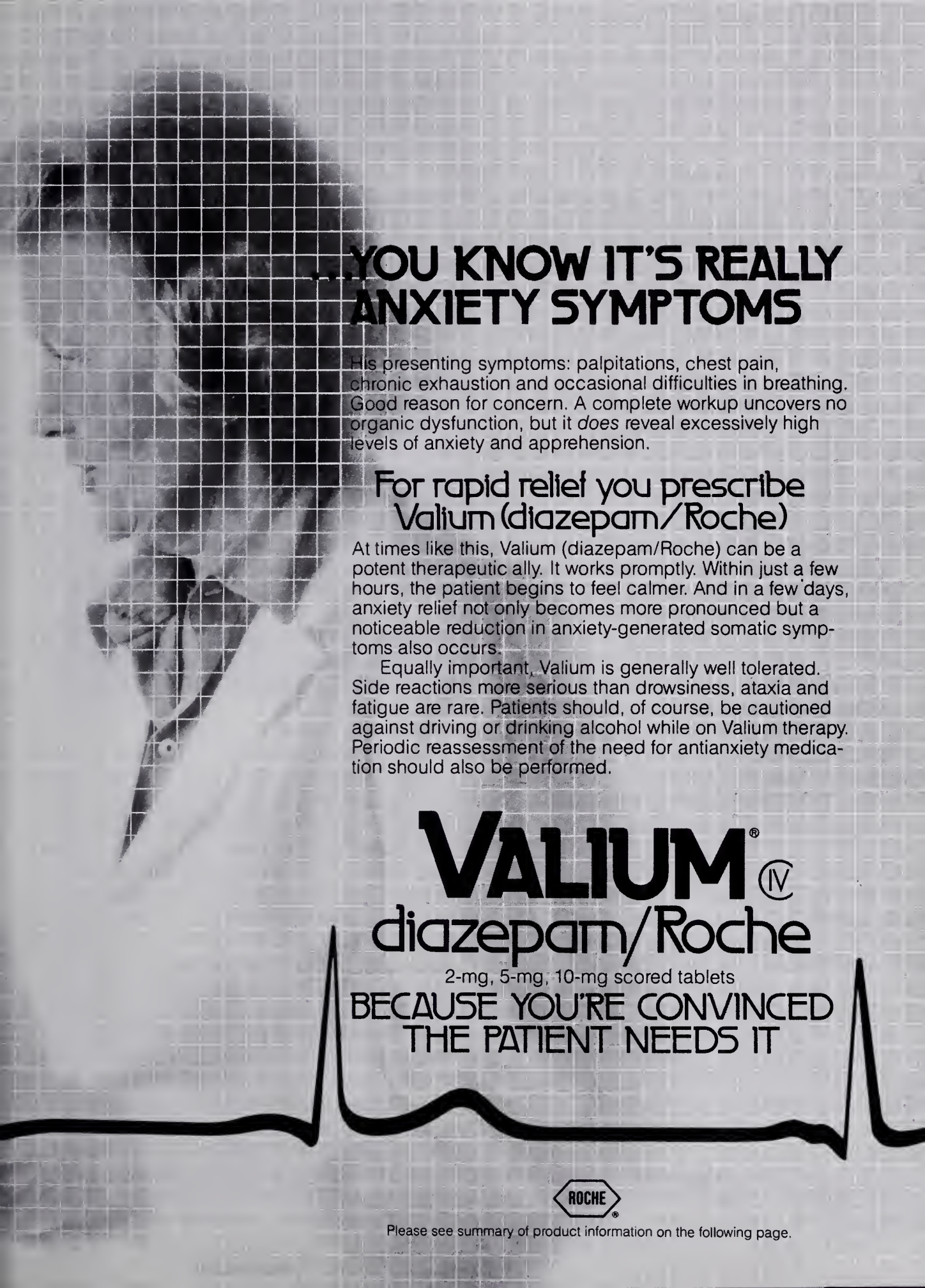
- 867 The President's Page
Florida Doctors and the American Medical Association
Sanford A. Mullen, M.D.
- 903 Organization
*Summary of the FMA Board of Governors Meeting,
October 7-8, 1981*
- 908 *Report of the FMA Committee on Professional Liability*
- 915 "The Process of Aging" is Theme for 108th FMA Annual Meeting
- 917 Medical News Around the State
- 918 FMA Auxiliary
Coping With Grief
- 919 Worth Repeating . . .
*Best Medical Judgment
Competition
Professional Courtesy*
- 922 Information for Authors
- 923 Book Reviews
- 929 Meetings
- 937 Deaths
- 939 Classified Advertising
- 942 Index to Advertisers
- 942 FMA Officers and Council Chairmen

Cover

The cover this month features the cooperation between the American Medical Association, state and county medical organizations. The Journal has devoted several articles within this issue to the AMA. (See pages 867, 873, 875, 899 and 902)

**THE PATIENT THINKS
HE HAS HEART TROUBLE...**





...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM[®] ^{IV}

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT



Please see summary of product information on the following page.

VALIUM® (diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma. may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500.* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.*

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701

†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110



ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

How to establish your practice... painlessly.

At National Medical Enterprises, we've had a lot of experience in establishing and building a practice.

We can offer you a choice of over 60 well equipped acute care hospitals coast to coast. We can offer you selected financial assistance. We can offer you professional management consulting.

We know what you want and how to get it for you.

So if you're a Primary Care Physician interested in a partnership, group or a solo practice, contact NME today.

We'll help you establish your practice...painlessly.

For further information, contact:
Raymond C. Prullitt, Director Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.

Call Toll-Free 800-421-7470
or collect (213) 479-5526.

NATIONAL MEDICAL
ENTERPRISES, INC.



"The Total Health Care Company."
An Equal Opportunity Employer M/F



President's Page

Florida Doctors and the American Medical Association

Why are more than 40% of the members of the Florida Medical Association not members of the American Medical Association? It is very startling to realize that there are only slightly over 7,000 AMA members in the 13,000 member Florida Medical Association. It is our hope to examine this most unfortunate state of affairs and do our part to help encourage all FMA members who have not joined the AMA to re-examine their reasons and to consider the importance of their participation in the single organization which is dedicated to the support of all of the doctors and all of their patients throughout this country.

Since it was founded in 1846, the American Medical Association has been the official organization and voice of the medical doctors of the United States. During its 135 years of existence the AMA has provided service to the citizens of the United States to a degree well in excess of that provided by any other organization of comparable size. The list of accomplishments of the AMA for the good of mankind are far too numerous to be listed in any short article but several of the more important activities deserve at least passing mention.

The AMA has been dedicated since its founding to the improvement of the scientific standards of medical practice at all levels. The role of the AMA in the development of medical education is an excellent example of the importance of its activities. From its early days in the 19th Century the AMA spoke out against inadequate standards of medical education throughout the United States. Although its beginning efforts were not very successful, the AMA never failed to support the concept that quality medical education was absolutely essential for the development of satisfactory medical

practice standards in the United States. In the first part of the 20th Century the AMA gave major support to Abraham Flexner as he prepared his report, "Medical Education in the United States and Canada," a work which led to dramatic improvements in medical education. This AMA dedication to the highest quality of medical education has never waived as the AMA, to this very day, is the spark behind multiple programs designed to keep medical education on a continuing course of improvement.

Many other efforts aimed at the improvement of scientific medical practice have been a continuing high priority effort of the AMA. The multiple speciality medical journals and other publications produced by the AMA are distributed throughout the world. Recently the AMA announced that in 1982 the AMA is joining with the Chinese Medical Association in publishing a new Chinese language edition of *The Journal of the American Medical Association*. The JAMA is already published in Japanese and there are French language editions in France and Switzerland. By early next year there will be a German language edition for physicians in West Germany, Switzerland and Austria and there will be Flemish and French language editions in Belgium.

The AMA has been the major factor in developing the system of medical specialties and in encouraging the development of the specialty boards to certify the quality of physicians in specialty practice. Its efforts in bringing reason out of chaos in the field of therapeutics is well known. It has consistently been working to eliminate the inappropriate use of dangerous drugs and to prevent all forms of drug and alcohol abuse.

The service of the AMA in public health has been one of its most important activities. The strong and effective system of public health services throughout our nation and in the individual states has been due largely to the pioneering efforts of the AMA many years ago. The number of lives saved and illnesses prevented and controlled by the public health system developed in the United States cannot be calculated but the eradication and control of many infectious diseases is ample proof of the effectiveness of this AMA effort.

The AMA maintains records on medical doctors from the day they matriculate at medical schools throughout their entire undergraduate education, residency training and practice years. These are, by far, the most comprehensive records on doctors available anywhere in the United States in any public or private institution. The AMA physician master file lists all doctors of medicine who are graduates of American medical schools who practice in the United States and who practice temporarily overseas. The file includes members and non-members of the AMA and graduates of foreign medical schools who reside in the United States. These AMA master files comprise the data base which must be used in any consideration of numbers and types of practices of physicians in the United States. At present there are more than 450,000 physicians listed. The records have been checked by several independent organizations and have been found to have an extremely high level of reliability.

One of the important activities of the American Medical Association has been its service as the voice of American medicine to the legislative and executive branches of the federal government. Its actions in the halls of Congress have been subjected to criticism at times but in all these efforts the AMA consistently bases its published policy statements and testimony on the principles and policies established by the AMA House of Delegates. The AMA has also given great support to the various state medical associations in their legislative activities.

The AMA is an example of virtually pure democracy in action. Any member of the Association has the privilege of presenting his ideas at the county medical society level and, gaining approval there, having these ideas go to the state association where the state house of delegates can act on the proposal from the county society level. If approval is received at the state level the item can be transmitted to the AMA House of Delegates for consideration in establishing AMA policy. The leadership of the AMA has been very careful over the years to base its activities on the policies established through the AMA House of Delegates.

In line with its legislative activities, the AMA has made a continuing effort over the years to prevent inappropriate encroachment of the government at all levels on the practice of medicine. The AMA has continually fought efforts to have a centralized form of control over the practice of medicine. The AMA believes that health planning and medical peer review should not be conducted by the federal government but should be the responsibility of local communities who best know what is needed in their areas. Unfortunately, time and space limitations prevent more details about AMA accomplishments and activities.

In view of the outstanding record and continuing excellence of achievement of the AMA it is difficult to understand why a significant number of medical doctors appear to be indifferent to being a part of the organization. No matter whether or not medical doctors belong to the AMA they directly and indirectly receive continuing benefits from the AMA. Most individuals who have given the matter serious thought believe that all practicing medical doctors have an obligation to participate in the AMA by being full members in addition to their obligation to be members of their state and county medical societies.

Part of the reason that some members of the FMA fail to join the AMA is that they really do not understand what the AMA is and what it stands for. All studies indicate that most medical doctors who understand the AMA want to be a member of it. Some individuals indicate that they do not choose to be a member of the AMA because they do not agree with a particular policy which the AMA espouses. This is not a valid argument because AMA policy statements are based on the consensus of the members through the democratic process of representation from the county to the state to the AMA House of Delegates as previously outlined.

It is obvious that the AMA will never have policies that please every single member on every single issue. Devoted husbands and wives can have a happy marital relationship in spite of disagreements on particular issues from time to time. The answer to an individual who says he or she will not belong to the AMA because of a disagreement on an AMA policy is to tell that individual to become personally involved and work to change the policy with which he or she is in disagreement.

As the tone of the federal government is changing under the Reagan Administration, with its strong indication that federal regulation of all aspects of medical practice will be greatly lessened, it is more important than ever for doctors to join together in their organization. The AMA must be the umbrella for all of the county and

state associations as well as specialty groups so that there can be a cohesive voice speaking for doctors and answering the continuing demands of the legislative and executive branches of government at all levels.

If through some strange quirk, the AMA were suddenly taken from the scene, it would be absolutely essential for the responsible medical doctors of the United States to establish a similar organization so that there could be a voice of medicine speaking to the federal government and providing leadership for the multiple state, county and specialty medical groups to carry out the needed services for doctors and their patients. Such an organization must also be available in order to continue the scientific programs and multiple other activities of the AMA.

Each FMA member who is not a member of the AMA is urged to review his or her situation and give careful consideration to the value of joining the world's

greatest medical organization, the American Medical Association. Although there are many specific benefits of AMA membership, such as subscriptions to the JAMA and a specialty journal of one's choice, the major benefit is being a full part of the national organization for all medical doctors. As more FMA members join the AMA there will be increased Florida representation in the AMA House of Delegates. AMA by-laws provide for one delegate for each 1,000 members or fraction thereof.

The AMA in its 135 years of existence has a sterling record of excellence in the encouragement of continually improving standards of medical education and practice; in the support of programs that help directly or indirectly the health of all people throughout the world, and in the protection of the practice of medicine from undue, inappropriate and deadening controls by government at all levels—controls which could only do irreparable damage to medical care. All non-AMA members of the FMA are urged to join the AMA as soon as possible.

Sanford A. Pullen, M.D.

"When I dance, I feel better and beautiful."

Melissa Berman is nine years old, deaf and a "natural dancer." She takes ballet at the Joffrey Ballet School where Meredith Baylis teaches a special class for the non-hearing. The children respond to the vibration in the floor and sometimes get their instruction through an interpreter.

Dance seems to offer an escape valve for the remarkable energy that would otherwise be bottled up in Melissa and her classmates. Melissa's mother reports that when "The Nutcracker" appeared on television, Melissa got up and joined in the dancing. Melissa is also an accomplished gymnast but her great love is dance which she hopes to pursue.

Here in the dance studio, with the pianist pounding away, Melissa is indeed beautiful!

President's Committee on Employment of the Handicapped
Washington, D.C. 20210

Produced by The School of Visual Arts Public Advertising System

CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications. Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Branchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae*

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia, and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

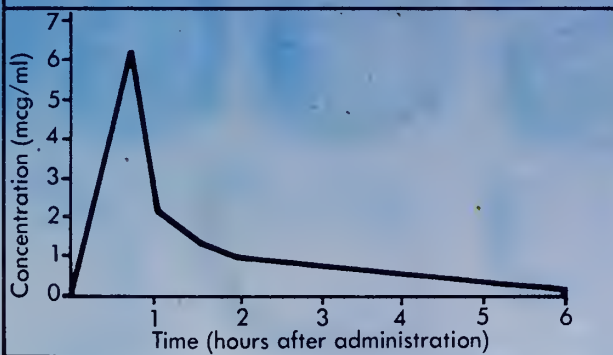
*Dosage should not result in a dose higher than that for adults.

†depending on severity

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on $T^{1/2}$ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.[†]

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

[†]Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

Wyeth Laboratories • Philadelphia, Pa 19101



NEW
NAME

- B-Complex Vitamins with Vitamin C.
- On b.i.d. dosage, smooth, continuous, predictable release all day, all night.
- Via micro-dialysis diffusion an improved delivery system.

B-C-BID CAPSULES

Wherever B-Complex with C Vitamins are indicated.

With B-C-BID there is maximum utilization and no "peaks and valleys" of absorption, as is common with ordinary capsules or tablets. No regurgitation. No after-taste.

For the patient who is debilitated, chronically ill, postoperative, on an inadequate diet for any reason—and wherever B-Complex with C will help speed the healing process, consider B-C-BID capsules.

EACH B-C-BID CAPSULE CONTAINS:

Vitamin B-1 (Thiamine Mononitrate)	15 mg
Vitamin B-2 (Riboflavin)	10 mg
Vitamin B-6 (Pyridoxine)	5 mg
Niacinamide	50 mg
Calcium Pantothenate	10 mg
Vitamin C (Ascorbic Acid)	300 mg
Vitamin B-12 (Cyanocobalamin)	5 mcg

DOSAGE: For continuous 24 hour therapy, one capsule after breakfast and one after supper.

Samples on request.

GERIATRIC PHARMACEUTICAL CORP.

397 Jericho Turnpike, Floral Park, N.Y. 11001

PIONEERS IN GERIATRIC RESEARCH SPECIALTIES.

ADVERTISED ONLY TO THE MEDICAL PROFESSION.

DEVELOPERS AND SUPPLIERS OF CEVI-BID • GER-O-FOAM • ISO-BID



The AMA: The Medical House of Glass

The AMA. Throughout its history, the name has meant many things to many people: a status quo-oriented association of stiff-necked dogmatism, an American institution bringing commentary into the arena of medical affairs, a large medical organization that helps support other medical organizations, organized medicine's debating society, the federal medical sovereignty, and so forth.

To the writer, the American Medical Association is like a glass house, a paradox. Few organizations have operated so completely in the glare of publicity; it is virtually a goldfish bowl. Yet despite all its translucence, the AMA remains widely misunderstood. Such is the paradox.

Sailing as it was compelled to do, without charts to guide it or precedent voyages of discovery, the AMA was guided by its founding fathers between rocks and whirlpools—between the demands of state societies, specialty groups and individuals jealous of a sovereignty, and the health care needs of a country destined to become the greatest power in the world.

The AMA has grown prodigiously in power and in its influence upon the medical needs of America and the entire world. The AMA has become an institution with all the term implies regarding roots and a respect for tradition. It is, for the American physician, a continuing body linked both to the past and the future.

Presidents of the AMA are not Titans. They are mortal men, generally endowed with more than ordinary intellectual powers and with exceptional richness of learning and experience, but nevertheless, subject like other men to eccentricities and failures of understanding.

From time to time the AMA has cause to acknowledge errors and correct itself, overturning its own past judgment, not capriciously on the basis of changing personal preferences, but rationally in the light of logic and experience.

Rhetorical flourishes and emotional outbursts against the AMA are increasing. Many members and non members alike complain of the vagueness and vacillation of AMA policy toward relations with unscientific practitioners. Some specialty societies question the AMA retaining a veto right over graduate medical education; individual specialty societies want greater control over the residencies in their specialties. Women physicians are concerned with the AMA's failure to endorse the Equal Rights Amendment.

The AMA is a glass house that affords an outlet for dissent, individuality, idiosyncrasy and a divergence from accepted official or conventional wisdom. Even the AMA's most passionate critics have to concede the value of most of its activities. Although there have been issues where the AMA's intentions and pronouncements were somewhat doubted, the physician members of the AMA have inevitably been the master of their own destiny and shall continue to be. In baseball parlance, the AMA has piled up a lot more hits than strikeouts.

Seldom in the course of American medical professionalism has the spirit of brotherhood been more sorely needed than it is today. The problems that we doctors face are of such a nature that they tend to divide rather than to unite us. We must realize that unselfish devotion to a common cause will strengthen individual faith.

We should remember that the conflict with socialized medicine in America today is between our form of free society, based on the primacy and moral worth of the individual, and the despotism of socialism in which the individual patient or physician is solely viewed as a small cog in a great inhuman machine.

The dynamism of a free society, despite its inherent faults and weaknesses, has a greater vitality and capacity to be adaptable than a rigid, monolithic American socialized medicine can ever hope to achieve.

We should not indulge in any premature rejoicing or loud hosannahs because a conservative now is President of the United States. This is no time to relax or to weaken our defenses, physical or moral; it is a time for unity, cooperation and collaboration, a time for interdependence of medical organizations. This is the time to strengthen, not to weaken, the AMA.

You do not frighten physicians into joining and supporting the AMA, any more than you frighten people into building a nationwide bomb-shelter system. You must convince physicians that the right, necessary and sensible thing to do is to join the AMA. Let us never forget that associations such as the League of Nations have failed because the members were not ready to live up to their obligations.

We must eliminate, or bridge, the chasm between the silent inactive majority and the dedicated active minority. Many physicians question the value of the network of associations into which the strands of

organized medicine have been woven. Some would reexamine, reduce, or even eliminate this network.

This web of interdependence owes its strength to the AMA's long-range policies and the Medical House of Glass's ability to rise above the maelstrom of immediate events and crises.

Outside isolationism provides the mechanism for breaking the web of interdependence. Physicians cannot isolate themselves from the organizations representing them.

We practice in a complex professional, economic and social framework that responds to a variety of pressures. Alone we cannot exert much influence on that framework, but collective and cohesive strength can make a difference.

If the AMA is found wanting, it is due to lack of member support rather than intrinsic weakness.

*Edward Pedrero Jr., M.D.
Assistant Editor
Tampa*

AMPAC Celebrates Its 20th Birthday

The American Medical Political Action Committee (AMPAC) celebrated its 20th birthday in Washington, D.C. on September 17 during a two-day Political Education Conference.

AMPAC was established by the AMA in 1961 as the second political education committee in the United States. COPE, the PAC of the AFL-CIO, was the first one.

Now there are thousands of PACs which serve as the political arm of many organizations and businesses. Every state medical society has its PAC, as do some county medical societies.

COPE was founded in 1943 as a reaction to the growing power of the anti-labor bloc in Congress. AMPAC was formed because of the rising tide of support for national health insurance in the Congress. This congressional support was generated in part by the aggressive promotion of national health insurance by COPE.

Under Federal Law, membership in PACs is voluntary. Sponsoring organizations of PACs cannot contribute money to candidates' campaign funds. Only PAC membership dues can be used for this purpose. Sponsoring organizations can, however, spend money for political education activities.

When AMPAC and the state medical PACs were first established, many physicians did not believe that they should be actively involved in the political process. They did not realize that successful participation in politics is essential to having successful legislative programs in both the Congress and the state legislatures.

Most of these physicians have now changed their minds because the very survival of free medicine based on the fee-for-service principle depends on success in both the political and the legislative arenas. AMPAC had a major role in changing these attitudes. AMPAC sponsored political education conferences in the late '60s and early '70s which were attended by medical leaders throughout the country. At these conferences, how-to-do-it materials and techniques were presented that could be used by physicians in political action. Many of these materials and techniques had been developed by AMPAC's Political Research Committee.

This latest conference was similar in many ways to earlier ones. It was well attended by representatives of both state medical societies and state PACs.

The first portion of the conference was devoted to a review of the current political scene in Washington and the congressional redistricting that will take place in 1982. Individual study groups then reviewed current methods for increasing PAC membership; and conducted get-out-the-vote drives, raising funds for candidates, recruiting winning candidates, and managing campaigns and campaign offices. The vital role of the medical auxiliary was stressed, as were the legal limitations on the use of independent expenditures in political campaigns.

The over-all theme of the conference was "Design for the Decade." Participants in this conference went home believing that they had sharpened their political tools and were ready for the turbulent politics of the '80s.

*F. C. Coleman, M.D.
President, FL AMPAC
Assistant Editor
Tampa*





PROFIT FROM OUR EXPERIENCE

For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

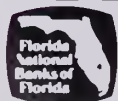
We specialize in attaining the results that you require from your account in the areas of:

- **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.
- **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.
- **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

PEOPLE WHO KNOW HOW.

Florida National Trust Services



214 Hogan Street
Jacksonville, Florida 32231
Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® for (lorazepam) Anxiety

Dosage: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

How Supplied: 0.5, 1.0 and 2.0mg tablets.



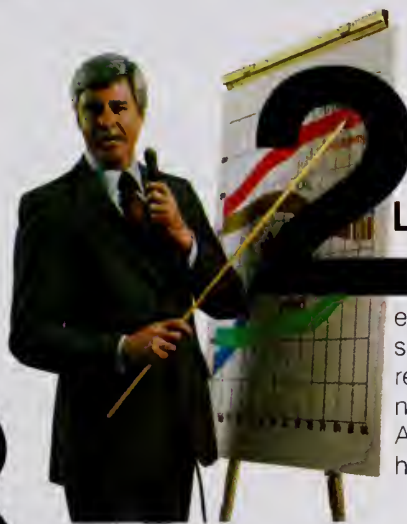
Four practical reasons to prescribe **Ativan[®]** **for** (lorazepam) **Anxiety^{*}**



1

No interaction with more than 300 drugs[†]

In clinical studies, Ativan was given concomitantly with hundreds of medications, including gastrointestinal and cardiovascular, with no reported interactions. Whereas the interaction of diazepam and cimetidine has been shown to cause increased sedation in patients taking both drugs, the clearance of Ativan is not delayed by Tagamet.[‡]



2

Lets most patients stay active

Long-acting benzodiazepines have long-acting metabolites with activity which can produce excessive accumulation that may lead to unwanted sedation. Ativan[®] has no active metabolites, reaches steady state in 2 to 3 days and usually does not cause oversedation. Also, the shorter half-life of Ativan is consistent with b.i.d. dosage, so drug hangover is seldom a problem the next morning.



3

Not appreciably affected by aging

Unlike the long-acting benzodiazepines—diazepam [®], chlordiazepoxide [®], clorazepate [®] and prazepam [®] — the metabolism and clearance of Ativan are not appreciably affected by the aging process.



4

Not significantly affected by liver dysfunction

Ativan[®] is metabolized in one simple step to an inactive glucuronide; its absorption and excretion are not significantly altered by cirrhosis or hepatitis. By contrast, the metabolism of diazepam and chlordiazepoxide has been reported to be significantly altered in patients with liver dysfunction.

^{*} Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic.

[†] All benzodiazepines, however, produce additive effects when given with CNS depressants, such as barbiturates or alcohol.

[‡] Tagamet (cimetidine) is a registered trademark of Smith Kline & French Laboratories, Division of SmithKline Corporation.

Copyright © 1981, Wyeth Laboratories. All rights reserved.

See important information on following page.

Wyeth Laboratories
Philadelphia, PA 19101

Introducing an innovative new way to own your own medical building.

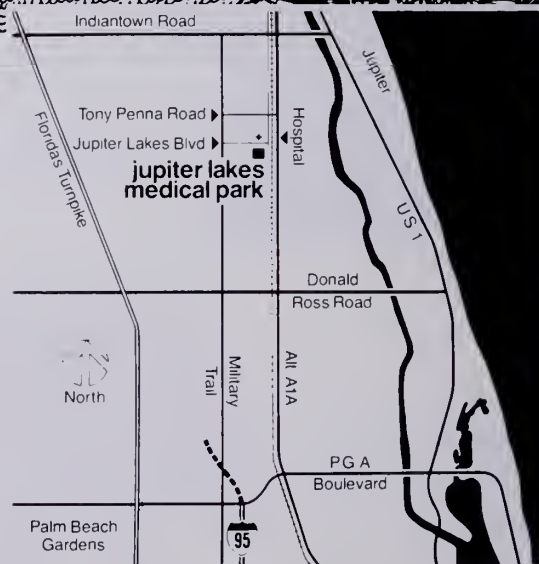


If you're a doctor who's given any thought to owning your own medical building or suite, then you need to know about Jupiter Lakes Medical Park. Because at Jupiter Lakes Medical Park, it can actually cost you less to own than it does to rent. And it doesn't require a large capital investment either.

Jupiter Lakes Medical Park has come up with a remarkable new plan called Leasehold Condominium. Basically, it's a plan that combines the low capital investment features of renting with the tax advantages of ownership. And, just as importantly, at Jupiter Lakes Medical Park your suite or building will be located across the street from the hospital in Jupiter, right in the middle of one of the fastest growing areas in Palm Beach County. But to get the whole story on Jupiter Lakes Medical Park, call or write for a free copy of our brochure.

jupiter lakes medical park

210 Jupiter Lakes Boulevard
(across the street from the Jupiter Hospital)
Jupiter, Florida 33458
Telephone (305) 746-6849



YES, I'd like to know more about Jupiter Lakes Medical Park and your Leasehold Condominium Plan. Please send me your brochure.

Name

Type of practice

Street

City State

Zip Phone

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

Second Annual

“INTERAMERICAN MEDICAL SYMPOSIUM”

“Cardio-Pulmonary, Renal and Hypertensive Disorders”

Sheraton Bal Harbour Hotel

December 13 - 17, 1981

Bal Harbour, Florida

In this Second Annual Interamerican Medical Symposium a distinguished **faculty from North, Central and South America** will review cardiopulmonary, renal and hypertensive diseases with special emphasis on the geographic characteristics and most recent modes of therapies. **Interdisciplinary Symposia** with open discussions will be the basic format. All presentations will be offered in **English and Spanish with simultaneous translation.**

CARDIOVASCULAR DISEASES

- Ambulatory Monitoring of Arrhythmias
- Coronary Artery Disease
- Diagnosis of Coronary Spasm
- New Techniques in Nuclear Cardiology
- Stress Tests
- Sudden Death — Pacemakers
- Surgery of Valvulopathies
- Vasodilators and Beta Blockers

HYPERTENSIVE DISEASES

- Adrenal Hypertension
- Cardiovascular Risks
- Complications of Drug Therapy
- Essential Hypertension
- New Antihypertensive Drugs
- Radiological Diagnosis of Hypertension
- Secondary Hypertensive States
- Work-up of the Hypertensive Patient

PULMONARY DISEASES

- Extrinsic Allergic Alveolitis
- Interstitial Pneumopathies
- Pulmonary Hypertension
- Pulmonary Thromboembolism
- Respiratory Insufficiency
- Reversible Airway Obstruction Syndromes
- Sleep-Apnea Syndromes
- Tuberculosis, Prophylaxis & Chemotherapy

RENAL DISEASES

- Acute Renal Failure
- Ambulatory Peritoneal Dialysis
- Glomerulopathies
- Lupus Nephropathy
- Nephrolithiasis
- Newer Renal Therapies
- Plasmapheresis
- Renal Osteodystrophy

24 credit hours in Category I of the Physician's Recognition Award of the American Medical Association and Mandatory Hours of the Florida Medical Association.

Registration Fee: \$200 before October 30, 1981 — \$250 after October 30, 1981

For registration and information write to: Jose S. Bocles, M.D., University of Miami, Department of Medicine (R-760), P.O. Box 016760, Miami, Florida 33101, U.S.A. Phone: (305) 547-6063

Free Yourself

TO DO WHAT YOU DO BEST

and Increase Your Cash Flow...

Your cash flow can be increased by 20% if you use the Medi-Serv South Medical Billing System. You can use this system on your own computer or purchase our "total" package that includes a computer. These dramatic



increases in cash flow are the result of incorporating our recommendations for streamlining your office procedures to most effectively use the computer, and changes in the "interface" procedures with inservice carriers and private account collection practices.

In most states \$18,000 buys you the complete package, our price is better — including Software, On-site training of your staff, and Implementation on your computer (customization to run on a non-Texas Instruments computer is limited to \$2,500.)

Want to get free ??? and increase that cash flow ???

Call or send the coupon for more information.



801 Meadows Road Suite 111
Boca Raton, Florida 33432
Office: 305-368-4437

Please send me information on

NAME

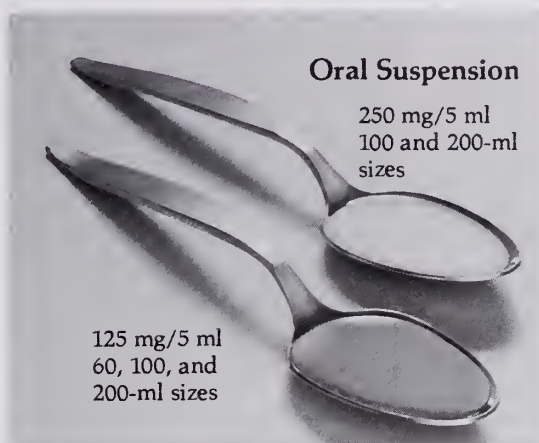
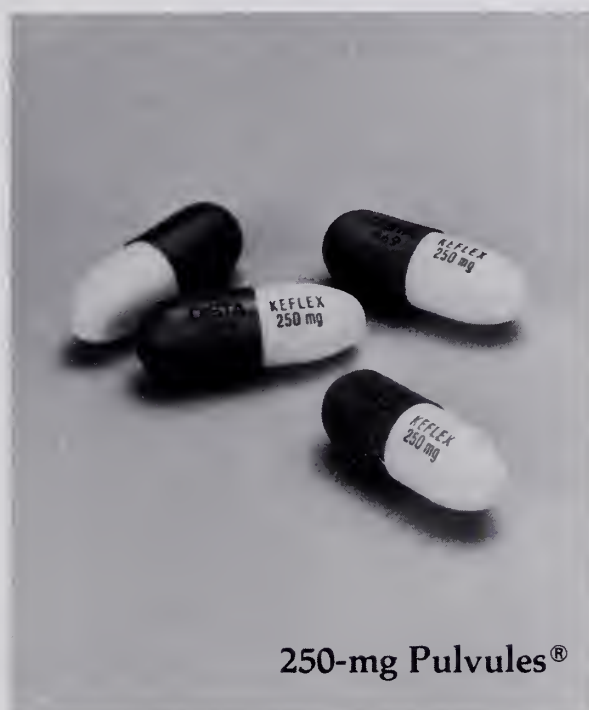
PRACTICE NAME

ADDRESS

CITY STATE ZIP

TELEPHONE

easy to take



Keflex®
cephalexin

Additional information available
to the profession on request.



Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

A tax-favored approach to post-retirement protection.

Introducing the exclusive FMA-sponsored Retired Lives Reserve.

"The FMA is proud of the many innovations it has pioneered on behalf of our members. We are pleased to present another, exclusively for you, designed to provide you with substantially greater financial flexibility, more secure estate maintenance, and peace of mind. I highly recommend the exclusive FMA-sponsored Retired Lives Reserve for your serious consideration."

Sanford A. Mullen, M.D.

Sanford A. Mullen, M.D.
President, Florida Medical Association

A dramatic new tool for personal and estate planning.

FMA and MAPS (the Mutual Association for Professional Services) are proud to offer an imaginative and innovative program designed to significantly strengthen your estate planning. It's a special version of The Penn Mutual Life Insurance Company's Wraparound Retired Lives Reserve, customized to provide meaningful benefits to FMA members, age 65 or less. It offers substantial lifelong coverage, low premiums, tax-favored status, and assured estate maintenance. It's a program exclusively and specifically for FMA members. No other organization can offer it.

Continuing protection. For life.

That's important. And unusual. Group term life insurance coverage by its very purpose and nature terminates or drastically diminishes when you retire. And the cost of continued coverage can be prohibitive. The FMA-sponsored Wraparound Retired Lives Reserve, on the other hand, picks up coverage on a pre-paid basis *even after you retire and stop paying premiums.*

Coverage up to \$300,000.

Most members can elect coverage up to \$300,000! That's another special feature not available in so-called "similar" programs.

Tax-deductible premiums.

One of the most advantageous—and unique—features of the FMA-sponsored Retired Lives Reserve is its tax-favored position. The premium rates, to begin with, are extremely attractive. And their tax-deductible status to corporations reduced your actual cost even more.

Your estate is protected. And productive.

High-value continuing coverage and tax-deductible premiums are obvious advantages. But there's more. Consider also that your post-retirement coverage provides a potential source of income-producing assets to your estate for your heirs. And the surety of a solid estate base allows you the option of converting other policies to annuity status for additional retirement income.

For FMA members only.

The FMA-sponsored Retired Lives Reserve is restricted to member physicians and their staffs.

No medical examination.

A medical examination is not required for eligibility.

Get the facts.

Space does not permit all of the outstanding benefits of the Wraparound Retired Lives Reserve program to be listed here. The FMA and MAPS urge you to acquaint yourself with the numerous benefits of this customized Retired Lives Reserve program. Mail the attached postcard to arrange a confidential appointment with a MAPS representative to see what this innovative plan can mean to you.

MAPS

Mutual Association
for Professional Services

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

NOVEMBER 1981
VOL 68 • NO. 11

Calcium Channel Blockers: Rationale For Their Clinical Use

C. Richard Conti, M.D.

Abstract: In the United States, the calcium channel blockers will soon be available for clinical use. Prior to that availability, physicians should be aware of the biologic role that calcium plays in cardiovascular cells. Intracellular calcium is necessary for smooth muscle contraction and for conduction in nerve tissues. The calcium channel blockers have as their common function the prevention of the utilization of intracellular calcium.

Three calcium channel blocking agents are commonly used, i.e., Verapamil, Nifedipine, and Diltiazem. Their actions vary slightly but most decrease systemic vascular resistance, decrease coronary vascular resistance, increase epicardial coronary arteries size, decrease myocardial contractility and alter atrio ventricular and sinus node conduction.

In patients with ischemic heart disease, calcium channel blocking agents work by increasing coronary blood flow and decreasing myocardial oxygen consumption.

I. Introduction

In August of 1981, the calcium channel blockers became available for clinical use in the United States. Unfortunately, only the parenteral form of this interesting group of compounds is presently available, i.e., intravenous verapamil (Calan, Isoptin). Our colleagues in Canada, Europe, Central and South America, and Asia have been using this form of the drug for several years with great success especially in the management of patients with supraventricular tachycardias. Hopefully, the oral preparations of the different calcium channel blockers will be available for our clinical use in the near future. Calcium blockers will provide the physician with a broader approach to the control of many different forms of heart disease. Thus, it will be important for the practitioner to understand their mode of action, their

interaction with other drugs and perhaps the combination use of different calcium blockers.

The purpose of this presentation is to provide a rationale for the use of slow channel calcium blocking agents by reviewing the role of calcium in cardiac function, summarizing the current use of these agents, and speculating on the future application of calcium blockers.

II. Calcium and Cardiac Physiology

To appreciate the role calcium blockers have in the treatment of heart disease, one must have a clear understanding of the biologic role that calcium plays in the excitation of cardiovascular cells, i.e., conduction tissue, myocardial cells, and smooth muscle cells in coronary and peripheral arteries. The action of cardiac pacemaker cells and all muscle contraction, whether in the myocardium, in vascular smooth muscle, or in skeletal muscle, depends on the availability of intracellular calcium ions. Calcium is essential for the interaction of the contractile proteins which are responsible for cardiac muscle contraction and smooth muscle contraction of

The Author

C. RICHARD CONTI, M.D.

Dr. Conti is Professor of Medicine and Chief of the Division of Cardiology, J. Hillis Miller Health Center, University of Florida, Gainesville.

peripheral and coronary arteries. The skeletal muscle cells have extensive stores of intracellular calcium that provide sufficient ions to generate contraction, but myocardial and vascular smooth muscle cells do not. Stores of intracellular calcium in myocardial cells are limited and therefore dependent on the influx of extracellular calcium for contraction to occur. The availability of intracellular calcium via transmembrane calcium flux determines the balance between contraction and relaxation. When contraction of the smooth muscle of the coronary artery occurs, vasoconstriction results. Thus, in vascular smooth muscle such as in the coronary arteries, calcium may play an important role in normal contraction that maintains coronary artery tone as well as in the pathologic states such as in patients with coronary artery spasm. Since excitation, contraction coupling of coronary smooth muscle is sensitive to the influx of calcium, inhibiting the flow of calcium into vascular smooth muscle prevents spasm and causes vasodilatation.

The calcium blocking agents have as their common function the prevention of the utilization of intracellular calcium necessary for smooth muscle contraction and in the case of the conduction system, blocking the utilization of calcium necessary for conduction in nerve tissue. There are numerous sites at which calcium can be

interrupted or inhibited to prevent or reduce muscle contraction. The different calcium blockers have different sites of action.

Three calcium blocking agents are commonly used, i.e., Verapamil, Nifedipine, and Diltiazem. These agents have different sites of action and, therefore, will have some different physiologic effects. For example, Verapamil significantly slows conduction in the AV node and the sinus node whereas Nifedipine does not. Thus, Verapamil is an effective agent to treat supraventricular tachycardia. Figure I is an example to illustrate the effect of intravenous Verapamil in a patient with supraventricular tachycardia.

III. Pharmacokinetics of the Calcium Blocking Agents.

Pharmacokinetics of the calcium blocking agents varies slightly; however, most blocking agents are readily absorbed in the GI tract and peak blood levels are obtained within several hours after oral use. For example, approximately 70% of Nifedipine when taken orally is detected in the blood within 20 minutes and when dissolved sublingually within 10 minutes. Peak blood concentration is recorded one to two hours after oral use. The drug is primarily eliminated by the kidney where 70-80% of it is excreted. The biologic half-life of Nifedipine is about four to five hours. Nifedipine has a much greater effect on calcium flux in smooth muscle than in cardiac muscle. Table I summarizes some of the pharmacokinetics of the three common calcium blocking agents used.

PHARMACOKINETICS OF CALCIUM ANTAGONISTS*

	Nifedipine	Verapamil	Diltiazem
Oral Dose (mg/8 hrs)	10-20	80-160	60-90
Absorption (%)	>90	>90	>90
Bioavailability (%)	65-70	10-22	<20
Onset of Action (Min)	<20	<30	<30
Excretion			
Renal%	80	70	35
Fecal%	<15	15	65

*Updated from Henry, P.D.: Comparative Pharmacology of Calcium Antagonists: Nifedipine, Verapamil & Diltiazem. Am. J. Cardiol. 46:1047-1058, 1980

Table I

IV. Physiologic and Clinical Effectiveness of Calcium Blocking Agents.

The calcium blockers have four major physiologic effects.

A. Decrease systemic vascular resistance. Because of this feature, several calcium blocking agents can be used to treat mild hypertension and/or congestive heart failure.

B. Decrease coronary vascular resistance and increase epicardial coronary artery size. As a result of

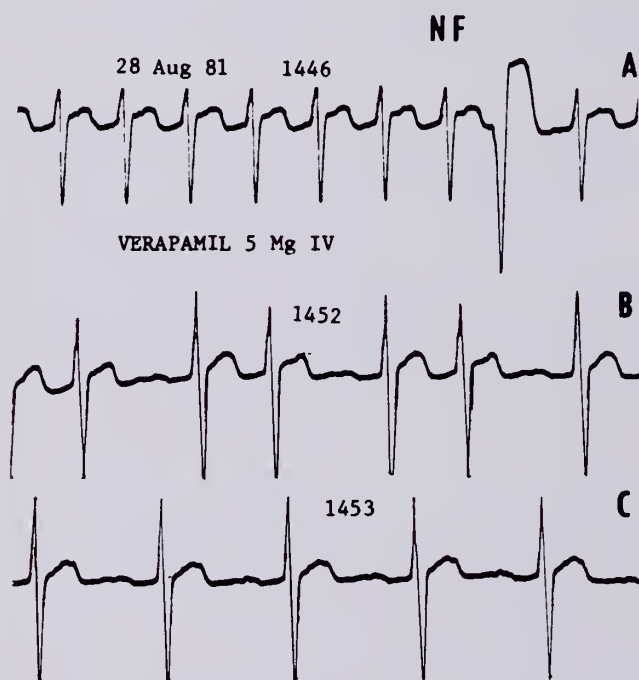


Fig. 1 — Typical response to intravenous verapamil in a patient with supraventricular tachycardia. Panel A shows the tachycardia prior to treatment with intravenous verapamil at 1446 hours. Verapamil, 5 mg, was then infused intravenously over a three minute period. Panel B taken at 1452 hours shows intermittent slowing of the heart rate. Panel C taken at 1453 hours reveals a return to sinus rhythm.

this action, there is an increase in coronary blood flow and myocardial oxygen delivery. Thus, these agents can be useful for the treatment of variant angina and patients with unstable angina pectoris. Most investigators report that patients with variant angina and continued symptoms despite nitrate, beta blockers, etc. respond favorably to the calcium blockers: Nifedipine, Verapamil, and Diltiazem.¹⁻⁴ In patients with unstable angina, both Nifedipine and Verapamil have been reported to be effective in reducing the number of symptomatic and asymptomatic episodes of myocardial ischemia.^{5,6}

C. Decrease myocardial contractility. As a result of this action, there is a decrease in myocardial oxygen consumption. Thus, these agents can be useful for the management of patients with effort angina secondary to obstructive coronary artery disease. Investigators have demonstrated the effectiveness of Nifedipine and Verapamil, used alone or in combination with nitrates and beta blockers, in patients with stable angina pectoris.^{7,8} In addition, the negative inotropic action of these agents probably accounts for their effectiveness in treating conditions such as idiopathic hypertrophic subaortic stenosis, in which stiffness and compliance of the ventricle is a major problem.⁹

D. A few of the calcium blockers slow AV and sinus node conduction (Verapamil especially), and as a result are useful for the treatment of supraventricular tachycardias.

V. Comparison of the Physiologic Effects of Nitrates, Beta Blockers and Calcium Blockers.

The aim of drug therapy in patients with angina pectoris is to reduce the oxygen consumption of the myocardium and increase coronary blood flow. It is well known that nitrates and beta blockers decrease myocardial oxygen demand by different mechanisms. Calcium blockers also reduce myocardial oxygen demands, but probably less than nitrates and beta blockers. The variable negative inotropic action of calcium blockers can have varying clinical effects depending upon the degree of cardiac decompensation. Theoretically, there may be advantages to combining beta and calcium blockers in some instances, but one must recognize that this may increase the risk of side effects. Still, most investigators have not reported this to be a major problem.

The calcium blockers uniformly increase coronary blood flow primarily by decreasing coronary vascular resistance, and increasing epicardial coronary artery size. In this regard, they are similar to nitrates but dissimilar to beta blockers, which generally increase coronary artery resistance and decrease epicardial coronary artery size. Table II is a detailed summary of the effect of nitrates, beta blockers and calcium blockers on

PHYSIOLOGIC EFFECTS OF NITRATES
B BLOCKERS AND CALCIUM BLOCKERS
ON DETERMINANTS OF MVO₂ and CORONARY BLOOD FLOW.

	Nitrates	Beta Blockers	Calcium Antagonists		
			Diltiazem	Verapamil	Nifedipine
Myocardial Oxygen Consumption					
Contractility	↑	↓	↓	↓	nc
Heart Rate	↑	↓	↓	↓↓	↓
L.V. Wall Tension					
Volume	↓	↑	?	↑	↓
Systolic Pressure	↓	↓	↓	↓	↓
Diastolic Pressure	↓	↓	nc	↓	nc
Coronary Blood Flow					
Aortic Pressure	↓	↓	↓	↓	↓
Coronary Resistance	↓	↓	↓	↓	↓
Epicardial Artery Size	↓	↓	↓↓	↓↓	↓↓

↓ = Significant Effect
 ↑ = Minor Effect
 nc = No Change

Table II

the determinants of myocardial oxygen supply and demand.

As a result of the decrease in systemic vascular resistance, systolic and diastolic arterial pressure usually decrease while heart rate and cardiac output generally increase. The end result of these changes is a decrease in cardiac work and oxygen requirements for the heart. Therapeutic doses of calcium blockers produce no change or only a slight decrease in myocardial performance because arterial vasodilation after calcium blockade usually offsets the negative inotropic effect of the drug.

VI. Current and Future Use of Calcium Blocking Agents.

Table III lists three calcium blockers and the oral dose range, used to treat patients with myocardial ischemia. The recommended dose range of intravenous verapamil to treat a supraventricular tachycardia in an adult patient is five to ten mg. given as an intravenous bolus injection over a two to three minute period. A typical patient will experience a gradual change, with intermittent slowing of the heart rate, followed by return to sinus rhythm as illustrated in Figure I. If the patient does not respond to the first dose, another bolus injection can be given, but not sooner than 30 minutes time after the first injection.

CALCIUM BLOCKERS

	Total Daily Dose	Dose Schedule
Nifedipine	40-120 mg/day	10 mg q.6.h.
Verapamil	240-480 mg/day	80 mg q.6.h.
Diltiazem	120-240 mg/day	60 mg q.6.h.

Table III

Table IV lists the current and future use of the calcium blocking agents. Most agree that the symptoms of angina pectoris can be modified or prevented by the administration of these drugs. A few studies have indicated that mild or moderate Systemic hypertension can be controlled by agents such as Nifedipine because of their potent vasodilator action. Other arrhythmias, secondary to myocardial ischemia, perhaps could be prevented or aborted by any of the calcium blocking agents provided the myocardial ischemia was relieved. There are a few reports of the treatment of congestive heart failure using calcium blocking agents. Improvement in the symptoms of heart failure result from the afterload reducing properties of the calcium blocking agents, i.e., decreasing peripheral vascular resistance. One should be cautious when using the calcium blocking agents in the management of patients with heart failure. The negative inotropic properties of these agents must be considered in the balance. The use of calcium blockers in patients with myocardial infarction has not been systematically studied. But, if myocardial infarction, and especially recurrent myocardial infarction, is related to coronary artery spasm, then it would be logical to consider the use in that instance. Investigators have recently reported the successful use of oral Verapamil in the management of patients with the hyperdynamic cardiomyopathies. Whether these drugs will be beneficial in the long run has yet to be determined. Studies are beginning in patients with cerebral vasospasm and other vasospastic peripheral syndromes, i.e., Raynaud's phenomenon. Thus far, only anecdotal data are available to indicate that calcium blocking agents may be useful in these patients.

There are no data to indicate that calcium blocking agents prevent sudden death. However, if the mechanism of sudden death is related to a ventricular arrhythmia secondary to myocardial ischemia, then the

prevention of myocardial ischemia might obviate the arrhythmia and consequently sudden death. Finally, recent preliminary studies have shown that Nifedipine, when added to the cardioplegic solution used in patients undergoing coronary bypass surgery, seems to have a beneficial effect on myocardial contraction in the immediate post-operative state.¹⁰ Perhaps use of this agent will also prevent some of the episodes of coronary artery spasm that are known to occur in the immediate post-operative time period.

VII. Summary.

Although the oral form of calcium blocking agents are still investigational in the United States, practitioners around the world attest to their clinical usefulness. Based on the results reported today, it seems obvious that this new class of agents will broaden our current medical management of patients with ischemic heart disease. Because of differences in the action of these drugs, it is particularly important for the practitioner to understand their mode of action and interaction with other agents. They should be used either alone or in combination with themselves or other drugs on the basis of sound clinical observations in the individual patient. Even when used properly and in maximum doses, it will become evident that these new agents will not cure the problem of ischemic heart disease; on the other hand, they will offer considerable flexibility to the practitioner who is managing patients with various forms of ischemic heart disease, e.g., angina pectoris, myocardial infarction, arrhythmias, etc.

References

- 1 Johnson, S.M.; Marutson, D.R.; Willerson, J.T.; Hillis, L.D.: A Controlled Trial of Verapamil for Prinzmetal's Variant Angina. *New England Journal of Medicine* 304:15,862-866, 1981.
- 2 Antman, E.; Miller, J.; Goldberg, S., et al: Nifedipine Therapy for Coronary Spasm, Experience in 127 Patients. *New England Journal of Medicine*, 302:1269, 1980.
- 3 Hill, J.A.; Feldman, R.L.; Pepine, C.J.; Conti, C.R.: Randomized Double Blind Comparison of Nifedipine and Isosorbide Dinitrate in Patients With Coronary Spasm. *American Journal of Cardiology* (in press)
- 4 Pepine, C.J.; Feldman, R.L.; Whittle, J.; Curry, R.C.; Conti, C.R.: Effect of Diltiazem in Patients with Variant Angina. A Randomized Double Blind Trial. *American Heart Journal*, 101:719-725, 1981.
- 5 Mehta, J.; Pepine, C.J.; Day, M.; Guerrero, J.; Conti, C.R.: Short Term Efficacy of Oral Verapamil in Rest Angina. A Double Blind Placebo Controlled Trial in CCU Patients. *American Journal of Medicine* (in press)
- 6 Moss, J.W.; Wertheimer, J.A.; Bodenheimer, M.L.: Efficacy of Nifedipine in Rest Angina Refractory to Propranolol and Nitrates in Patients with Obstructive Coronary Artery Disease. *Annals of Internal Medicine* 94:425-429, 1981
- 7 Fox, K.M.; Jonathan, A.; Selwyn, A.P.: The Use of Propranolol and Nifedipine in the Medical Management of Angina Pectoris. *Clinical Cardiology* 4:125-129, 1981.
- 8 Bullion, M.; Rosing, B.; Bonow, R.; Lipson, L.; Epstein, S.: Clinical Efficacy of Verapamil Alone and Combined with Propranolol in Treating Patients with Chronic Stable Angina Pectoris. *American Journal of Cardiology* 48:131-139, 1981.
- 9 Rosing, D.R.; Kent, K.M.; Maron, B.J.; Epstein, S.E.: Verapamil Therapy: A New Approach to the Pharmacologic Treatment of Hypertrophic Cardiomyopathy. II. Effects on Exercise Capacity and Symptomatic Status. *Circulation* 60:128, 1979.
- 10 Clark, R.; Christlieb, I.; Ferguson, T.; et al: Enhanced Myocardial Preservation in Animals and Man with Nifedipine and Cardioplegia. *American Journal of Cardiology* 47:416, 1981.

- Dr. Conti, Box J-277, JHM Health Center, Gainesville 32610.

CALCIUM BLOCKING DRUGS

CURRENT AND FUTURE USE:

1. Treatment of:
 - A. Angina
 - B. Hypertension
 - C. Cardiac Arrhythmias
 - D. Heart Failure
 - E. Myocardial Infarction
 - F. Cardiomyopathy
 - G. Cerebral Vasospasm
 - H. Other Vasospastic Syndromes (i.e., Raynauds)
2. Prevention of Sudden Death
3. Myocardial Preservation

Table IV

Rationale and Methods of Splenic Preservation

Roger Sherman, M.D., FACS

Abstract: A comprehensive review of the world's literature regarding trauma to the spleen reveals that splenectomy, regardless of degree of splenic injury, became the procedure of choice, not because of failure of more conservative operative management (tamponade, partial splenectomy, suture repair) but rather that no important function of the spleen could be identified.¹

Reports of survivors without sequelae following splenectomy date from the sixteenth century. These, coupled with animal experiments suggesting that splenectomy was without serious ill effects, supported the concept that the spleen was not necessary for life. Accordingly, by the mid-twentieth century, all of many reports of successful treatment of injuries to the spleen by suture, tamponade, and partial resection had vanished from the literature.

The Spleen and Infection

In 1919, the first well-designed animal experiment demonstrated that in rats, removal of the spleen increased mortality from rat plague bacillus². This paper, published in a surgical journal, included an admonition to surgeons to be cautious in removal of the spleen.

The first undisputed challenge to the concept that the spleen plays no role in host defense against infection appeared in 1957. King and Schumacker reported an increased susceptibility to infection and deaths from sepsis in infants following splenectomy for spherocytosis³.

Others soon confirmed that severe infection and deaths in children due to fulminating sepsis was indeed a hazard after splenectomy for hematooncologic disorders, particularly in younger children. At first it was the impression that serious sepsis was not associated with splenectomy for trauma. In time, however, reports of severe infections and deaths from overwhelming sepsis following splenectomy for trauma in children accumulated. In 1970, the first death in an adult from sepsis following splenectomy for trauma was reported. Subsequently, case reports of post-splenectomy sepsis in adults continue to be published.

Post-Splenectomy Sepsis

The characteristic clinical picture of post-splenectomy sepsis begins suddenly, with nausea, vomiting, headache, and confusion leading to coma. The infection is usually fulminant, progressing rapidly to death within a few hours of onset of the first symptom. The infecting organism is the pneumococcus in just over 50% of cases. *Meningococcus*, *E. Coli*, *H. influenzae*, *Staphylococcus*, and *Streptococcus* are found with decreasing frequency. Disseminated intravascular coagulation is common. Waterhouse-Friderichsen syndrome is seen in many cases. Rapidity, of course, from onset until death, with failure of antibiotic therapy is characteristic. The mortality rate exceeds 50%.

Incidence

The incidence of overwhelming sepsis following splenectomy for trauma is difficult to establish from review of the literature¹. It would seem that related to the reason for removal of the spleen, the mortality rate from overwhelming sepsis varies from 50 to more than 200 times the incidence in the population at large. The incidence of sepsis following splenectomy for trauma is less than for hematooncologic diseases, but young children would seem more susceptible following trauma than older children and adults.

Infection following splenectomy usually occurs within two years after removal of the spleen. There is no time limit, however, as fatalities as long as twenty-five

The Author

ROGER SHERMAN, M.D., FACS

Dr. Sherman is with the Department of Surgery, University of South Florida College of Medicine, Tampa.

years following splenectomy for trauma have been reported⁴.

Splenic Function

The spleen participates in the cellular aspects of antibody production by stimulating the manufacture of IgM antibodies against circulating bacterial antigens, encapsulated or unencapsulated. The spleen is the sole source of tuftsin, a specific cell-bound leukophilic gamma globulin fraction essential for maximal stimulation of phagocytic activity of blood neutrophils in man. The spleen is also an important organ in the regulation of both T and B lymphocytes.

One conclusion is clear from review of the extensive and sometimes contradicting literature generated since the celebrated publication of King and Shumacher. The risk of bacterial sepsis related to splenectomy performed at any age and for any reason has been clearly defined. That the spleen plays a major role in host defense to infection is no longer controversial.

Alternatives to Splenectomy

A number of measures to reduce or eliminate the devastating complication of post-splenectomy sepsis must be considered. They include non-operative management, surgical repair, partial splenectomy, prophylactic pneumococcal vaccine and antibiotic prophylaxis. Deliberate autotransplantation of portions of the spleen based on the possible protective role of splenosis in patients with post-traumatic splenectomy has been suggested.

The reliability of peritoneal lavage and of radioisotope scanning for diagnosis and follow-up of splenic injuries have permitted non-operative management in carefully selected patients. Non-operative treatment has been shown to be safe in the pediatric age group when great care in patient selection is exercised, and provided that facilities for careful observation and follow-up are available. There is presently no evidence that non-operative management is equally applicable to adults. In any case, the risk of non-operative management is the possibility of missing a serious associated injury.

Splenorrhaphy or Partial Resection

Successful partial splenectomy was first accomplished in 1867; successful suture repair of splenic injuries dates from Zikoff's report in 1895. Modern splenorrhaphy was described by Dretzka in 1930. Recent confirmation of the segmental distribution of the arterial supply of the spleen by a number of surgeons and

introduction in 1973 of microfibrillar collagen, a reliable topical hemostatic agent, have been responsible for more than 200 case reports of splenorrhaphy and partial splenectomy in the recent literature. Laparotomy with careful abdominal exploration, hemostasis, removal of all clots, debridement, and repair of splenic injuries combines the advantages of splenic preservation and exploration to rule out associated injury.

There are many ways to repair the injured spleen, dictated by the pathology of the splenic wound. Adequate mobilization and exposure of the spleen is a prerequisite for successful repair by an indicated technique. Capsular tears and lacerations of the splenic parenchyma are treated by mattress sutures of absorbable suture material, or sometimes by simple suture techniques. Omental patching and hemostatic adhesives will sufficiently control most injuries. Ligation of the splenic artery or of its individual branches will be indicated on occasion.

There will always be some patients with such extensive injuries that splenectomy is mandatory. Prophylaxis against overwhelming sepsis in these patients is a responsibility of the surgeon. Options include deliberate autotransplantation of portions of the spleen, pneumococcal vaccination and antibiotic prophylaxis.

Deliberate Autotransplantation

Pearson has suggested that retained splenic tissue (splenosis) following traumatic rupture of the spleen might be responsible for protection against overwhelming sepsis. Clinical reports, however, of overwhelming sepsis in patients with remaining accessory spleens or extensive splenosis would seem to raise questions about the ability of autotransplanted spleen fragments to protect against sepsis⁵.

Short-term experiments have suggested that autotransplanted splenic fragments will not protect animals from pneumococcal challenge. Further studies of this kind must be done before the role of autotransplantation of the spleen for control of post-splenectomy sepsis can be evaluated.

Pneumococcal Vaccine

Polyvalent pneumococcal vaccine has been shown to be well-tolerated and to offer great promise for effective control of illness caused by pneumococci in normal individuals. Unfortunately, pneumococcal vaccine cannot be relied upon for protection in a number of clinical situations; nevertheless, vaccination is indicated.

Antibiotic Prophylaxis

There are a number of disadvantages of prophylactic antibiotics. Chief among them are the problems of compliance and inadequate dosage. Patient compliance, especially with long-term antibiotic prophylaxis programs (rheumatic fever) have been disappointing. Case reports of post-splenectomy sepsis due to penicillin-sensitive organisms in patients purported to be on prophylactic penicillin are disturbing. Since there are no controlled studies to validate the efficacy of prophylactic penicillin in prevention of post-splenectomy sepsis, and because patients may have a false sense of security while on antibiotics, they are not recommended.

Conclusions

1. From all available information, it is clear that as much viable splenic tissue as possible should be preserved in its normal location as the best solution presently available for prevention of overwhelming post-splenectomy sepsis.

2. Conservative (non-operative) management of injuries to the spleen can be successful, especially in children. There is no evidence that a similar approach will be effective for adults.

3. A number of techniques, including debridement, arterial control, hemostatic agents, omental patching, and suturing methods make repair of splenic injury practical.

4. The role of deliberate autotransplantation of splenic tissue in host defense against infection has not been defined.

5. Patients with splenectomy for trauma should be immunized with polyvalent pneumococcal vaccine. The limitations of protection must be clearly understood. Appropriate intervals for "booster" injections, although indicated, are not clear at this time.

6. Although prophylactic antibiotic therapy may be indicated for young children, older children and adults should not, at this time, rely on antibiotic prophylaxis for a number of reasons. Prompt medical attention should be emphasized for patients without a spleen who develop any significant febrile illness.

7. Aside from splenic preservation, ideal methods for prevention of post-splenectomy sepsis are not presently available.

References

- 1 Sherman, R. Perspectives in Management of Trauma to the Spleen. 1979 Presidential Address, American Association for the Surgery of Trauma. *J. Trauma* 20: 1-13, 1980.
- 2 Morns, D.H.; Bullock, F.D.: The Importance of the Spleen in Resistance to Infection. *Ann. Surg.* 70: 513-521, 1919.
- 3 King, H.; Shumacker, H.B., Jr.: Splenic Studies: I. Susceptibility to Infection After Splenectomy Performed in Infancy. *Ann. Surg.* 136: 239-242, 1952.
- 4 Grinblat, J.; Gilboa, Y.: Overwhelming Pneumococcal Sepsis 25 Years After Splenectomy. *Am. J. Med. Sci.* 270: 523-524, 1975.
- 5 Davis, C., Jr.; Alexander, R.W.; DeYoung, H.D.: Splenosis: A Sequel to Traumatic Rupture of the Spleen. *Arch. Surg.* 86: 523-533, 1963.

• Dr. Sherman, Box 16, 12901 North 30th Street, Tampa 33612.

Pure Red Cell Aplasia With Thymoma: A Case Report and Brief Review of Pathogenesis

Garnett R. Earlywine, M.D. and Fernando A. Rubio Jr., M.D.

Abstract: Pure red cell aplasia has been frequently cited as occurring in association with a variety of disease states such as chronic infections, exposure to chemicals, drugs and certain toxins, autoimmune disorders and certain tumors, with thymoma being the most notable. Correction of the underlying disease process or removal of the toxic substance usually leads to improvement of the pure red cell aplasia. Response to thymectomy has been variable.

The case report describes a patient who presented with pure red cell aplasia and negative chest x-ray. Additional studies identified the presence of a thymoma. Complete remission occurred post-thymectomy. This discussion describes the diagnosis and treatment of this patient and provides a brief summary of the pathogenesis of pure red cell aplasia.

Polayes and Lederer first reported the association of an anterior mediastinal mass and red cell aplasia in 1930.¹ Since their writing, numerous reports have appeared which thoroughly document the association of thymoma with pure red cell aplasia.^{2,8,11,14,20,24} In recent years several authors have concerned themselves with the study of the pathogenesis of pure red cell aplasia with and without associated thymomas.^{6,12,15,19,21,23} These studies have strongly implicated an abnormality of the immune system as a prominent etiologic factor.

We recently studied a patient who presented with pure red cell aplasia (PRCA). A discussion of the diagnosis and successful treatment of this patient and a review of the pathogenesis of pure red cell aplasia and its association with thymoma are the basis of this report.

Clinical History

The patient is a 67-year-old white male who presented on October 30, 1979, complaining of weakness, fatigue and dizziness. The patient was known to

suffer from Parkinson's disease which responded well to Sinemet. He was taking no other medication.

He denied blood loss or history of peptic ulcer. Review of systems was essentially normal and his past history and family history were unremarkable.

Physical examination revealed blood pressure 120/50, pulse 68 and respirations 20 per minute. The patient's tongue and palms were somewhat pale. There was no lymphadenopathy or splenomegaly. The only other significant findings were occasional dystonic movements of the face and right shoulder.

Laboratory studies showed WBC 3,900 cells/mm³ with a differential of 53 segs, 3 bands, 26 lymphs, 7 monos and 6 eos. RBC count was 2.09 million/mm³. Hemoglobin was 6.6/gm% and hematocrit 18.6%. Indices showed MCV 89.0, MCH 32.2 and MCHC 36.2. The platelet count was 365,000. The reticulocyte count was 0.0% on several preparations. The Coombs' tests, both direct and indirect, were negative. Total bilirubin was 1.7/mg% with direct 0.2/mg%. Serum iron was 240/mg% and TIBC was 240.

The peripheral blood smear was essentially normal. A bone marrow aspirate showed a normocellular marrow with normal morphology and maturation of the granulocytic series. Megakaryocytes and platelets were also normal. However, only rare "erythroblasts" were identified but nucleated red cell forms were completely

The Authors

GARNETT R. EARLYWINE, M.D. and FERNANDO A. RUBIO JR., M.D.

Dr. Rubio is Director of Hematology, Bayfront Medical Center, St. Petersburg, and Dr. Earlywine is Resident in Pathology.

absent. The erythroblasts occasionally showed prominent cytoplasmic vacuolation. Also noted were scattered but significant numbers of mature small lymphocytes often intermingled with mature plasma cells. Bone marrow iron was present.

A chest x-ray was normal but tomography and CT scans confirmed the presence of an anterior-superior mediastinal mass which measured 8-10 cm in its greatest diameter (Figs. 1 and 2).

The patient was transfused to a hemoglobin of 12 gm %. On November 19, 1979, the mediastinal mass was completely removed. The tumor showed no signs of invasion of adjacent structures and microscopically proved to be a mixed lymphocytic and epithelial thymoma (Fig. 3). Several of the epithelial areas consisted of a prominent spindle cell pattern. The patient did well postoperatively, but continued to show an absence of reticulocytes.

A repeat bone marrow study on December 11, 1979 showed persisting pure red cell aplasia. However, rare and scattered polychromatophilic and orthochromic normoblasts were seen in this aspirate. The mild lymphocytosis and plasmacytosis seen in the previous marrow were still present. Intracellular iron at this time was definitely increased.

Reticulocytosis developed approximately six weeks post-thymectomy (Fig. 4). Later studies showed gradual improvement of the patient's hemoglobin values and by mid-February 1980, the hemoglobin was within normal limits at 14/gm %. The mild leukopenia also corrected to 8,500. One year later the patient continues to do well and all hematologic studies are within normal limits. He is on no medication except Sinemet.

Discussion

Acquired pure red cell aplasia may occur secondary to or in association with a number of disease states such as infections, drugs or chemicals, hemolytic anemias with aplastic crises, acute severe renal failure, severe nutritional deficiencies or certain neoplasms.^{8,20} This form of the disease is usually of acute onset and is self-limited.

The primary form with immunologic implications in its pathogenesis is frequently associated with thymoma, SLE, rheumatoid arthritis and other diseases of abnormal immunity and serves as the subject of this discussion. These cases present insidiously and are characterized usually by a protracted course.⁸

Despite the apparent rarity of PRCA, more cases are being recognized and reported. The disease is probably not so uncommon, as might be suspected from surveying the list of causative and associated conditions. Accurate descriptions of the true incidence of

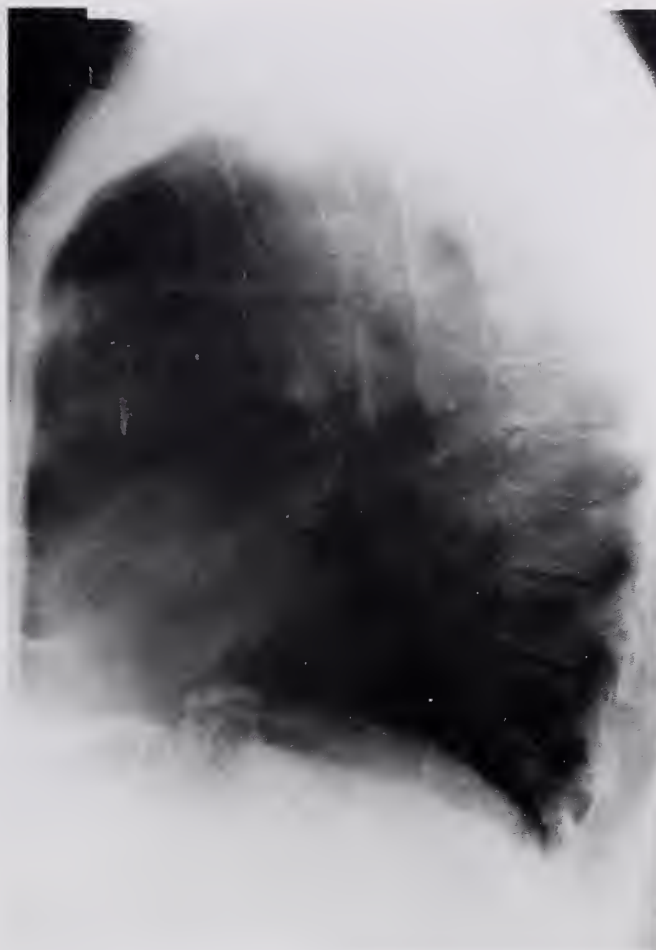


Fig. 1. — Lateral chest x-ray showing no evidence of an anterior-superior mediastinal mass.

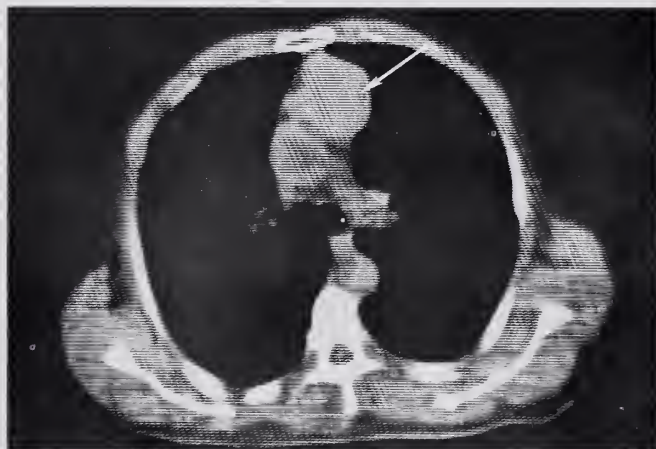


Fig. 2. — CT scan showing an anterior-superior mediastinal mass.

PRCA are not available.

Patients present with symptoms and signs of anemia which usually is moderate to severe and normochromic,

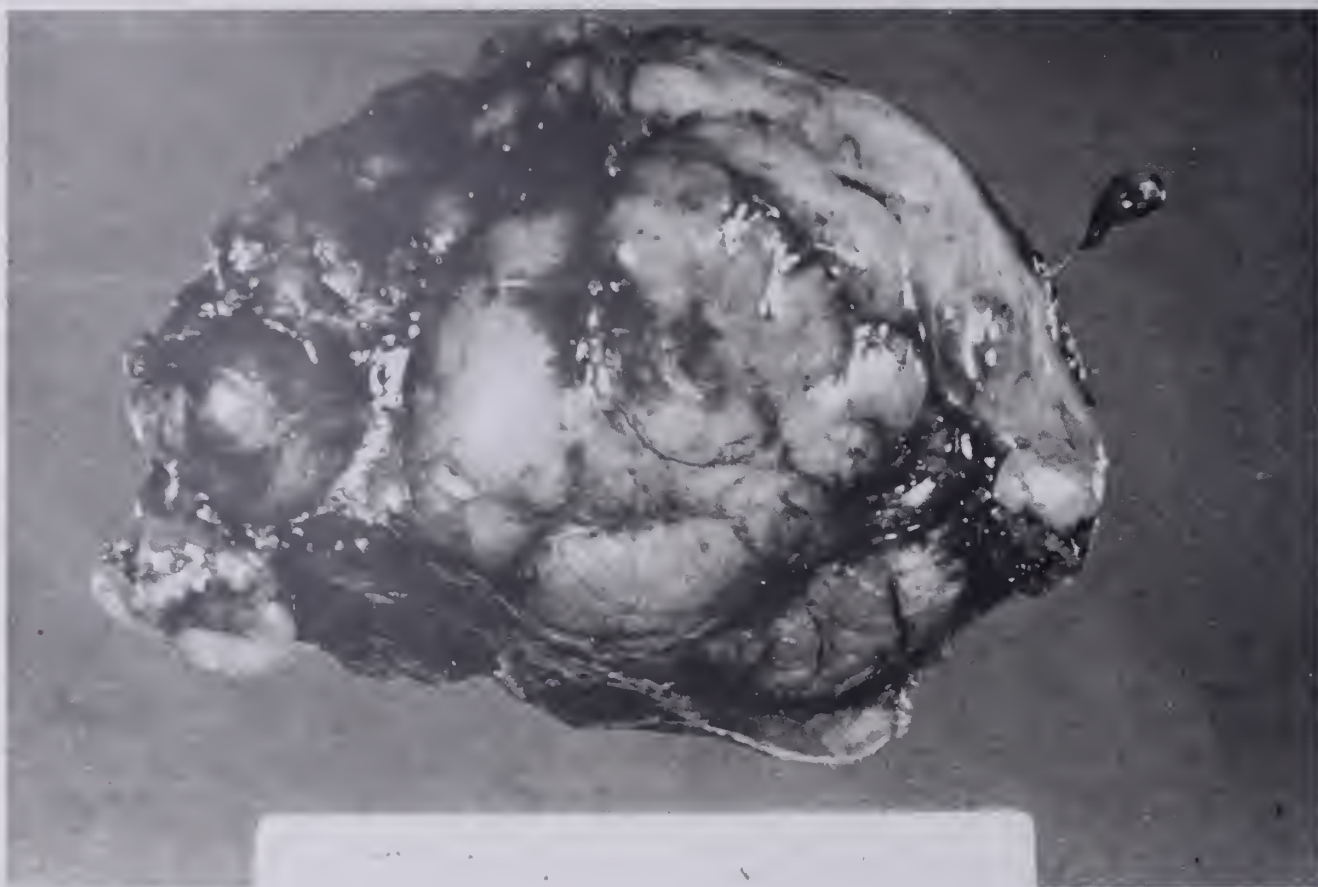


Fig. 3. — A 10 cm lobulated and encapsulated mass removed from anterior-superior mediastinum - diagnosis, benign thymoma.

normocytic. The clue to the diagnosis is a reticulocyte count of 0.0%. The total white count, differential and platelet count are normal or slightly decreased. Iron studies show an elevated serum iron with decreased TIBC and high percent saturation.

The bone marrow is typically normocellular with normal maturation and morphology of the white cell and platelet series. However, red cell precursors are rare (or totally absent) or immature. Scattered foci of plasma cell aggregates are present in a significant percentage of cases.^{8, 12,24}

The pathogenesis of PRCA has been the subject of numerous studies. Several authors have now amply documented the existence of a serum inhibitor to red cell genesis in patients with PRCA, with and without an associated thymic tumor.^{6,7,12,15,16} This inhibitor has been shown to be an immunoglobulin localized to the IgG fraction. The IgG immunoglobulin has been shown to be present in the patient's serum when the anemia is present and to disappear when the anemia is in remission, which may occur after thymectomy and/or immunosuppressive therapy.

The target antigen for this gamma globulin has also been the subject of recent investigation. At least two

different antigens are suspected experimentally. This finding corresponds with two clinically different forms of the disease; namely, (a) one group of patients with elevated or normal erythropoietin levels and (b) the remainder of patients who show a decreased erythropoietin level. Krantz and others^{9,10} in a study of the former group of patients have shown with immunofluorescent methods that the antibody inhibitor is directed against red blood cells of the patient's marrow. By using ⁵⁹Fe incorporation in conjunction with erythropoietin stimulation to study hemesynthesis, Krantz and others have also shown decreased hemesynthesis by cells from these patients' marrows after incubating the cells with the same patients' plasma. Substituting normal plasma with the same cells showed normal hemesynthesis. The patients' marrows were restudied using the same techniques during remission of their disease and normal hemesynthesis was noted. Lastly, when patients' plasma obtained during active disease (anemia) was added to normal marrow cells in an identical system, hemesynthesis by the normal marrow cells was diminished.

In studies of the second group of patients with decreased erythropoietin levels, Peschle et al¹⁶ have shown a similar IgG antibody which appeared to be

directed against erythropoietin. He illustrated this by incubating these patients' serum IgG with erythropoietin. This resulted in complete neutralization of the erythropoietic activity. In addition, this activity could be restored by exposing the patient's serum IgG to acidification and boiling.

Additional pieces of evidence add support to the role of an immunologic abnormality in the pathogenesis of PRCA. The disease has been frequently cited in association with other pathologic conditions characterized by well recognized immunologic abnormalities. These conditions include autoimmune hemolytic anemia, rheumatoid arthritis, systemic lupus erythematosus, myasthenia gravis, chronic lymphocytic leukemia, multiple myeloma, hypogammaglobulinemia, and paraprotein states.^{21,21} Also, some patients with PRCA can be expected to completely or partially respond to various immunosuppressive agents such as Cytoxan, steroids, antilymphocyte globulin and splenectomy. (Even the congenital form of the disease known as Diamond-Blackfan-syndrome is highly steroid responsive.⁸

Approximately 40-50% of adults with PRCA will harbor a thymoma. About 5% of patients with thymomas will have pure red cell aplasia. The association between these two disease processes remains unclear. It was suggested that the thymoma might secrete an inhibitor which has an antierythropoietin function. However, only one report has illustrated such an inhibitor in extracts of thymic tumor tissue.²⁵ In addition, occasional cases of PRCA have been reported to develop several years after the mediastinal mass was first discovered.^{5,6} Some reports have shown the anemia to develop one to two years after complete removal of the thymoma. Case report studies have also shown that only 30% of the PRCA remit after thymectomy, and the remission may be delayed.^{8,14} The serum inhibitor (IgG) referred to previously has been reported to disappear after thymectomy in some cases.

Of particular importance is the fact that the thymoma may not be evident by chest x-ray. Tomography and special radiologic procedures are therefore indicated in cases of PRCA where the etiology is not obvious. In most cases, the thymomas are benign and frequently of the spindle cell type.⁵

While the exact nature of the association between PRCA and thymoma is not clear, it is quite possible, as pointed out by Krantz,⁸ that a direct relationship as to cause and effect does not exist. Rather, both may arise as a result of an abnormality (? immunologic) which remains to be clearly defined.

An analogous situation exists in Castleman's disease or giant follicular lymph node hyperplasia. These patients present with a mediastinal or otherwise localized mass, frequently associated with the syndrome of refractory

hypochromic microcytic anemia, hypergammaglobulinemia and growth retardation, all corrected by surgical removal of the mass.²⁶ One case report²⁷ of an 11-year-old female presenting with such a mass of the gastrolineal ligament demonstrated a serum inhibitor directed against an erythropoietic factor. The serum inhibitor disappeared within six days after surgical removal of the mass. Follow up studies of the patient showed complete correction of the anemia, increased growth rate and disappearance of the hypergammaglobulinemia.

Treatment of pure red cell aplasia depends on which form of this disease is present. PRCA in its secondary form usually responds well to correction of the underlying cause, such as removing the patient from the drug or chemical toxin, correcting the renal failure, or treatment of the infection. However, treatment of the primary form of PRCA is not as simple and its prognosis is less predictable.⁸ The success of thymectomy in those patients with thymoma has already been mentioned. Some success has been achieved with therapeutic regimens aimed at immunosuppression. Those patients with thymomas not responding to thymectomy may improve with steroid therapy. Cases not associated with thymomas frequently have a good response to certain alkylating agents, corticosteroids, antilymphocyte globulin, or splenectomy alone or in combination with chemotherapy. However, recurrence of the disease is common. Some patients have responded to immunosuppression, even when serum immunoglobulin inhibitors could not be documented. Response to treatment may develop within a few weeks to several months.⁸

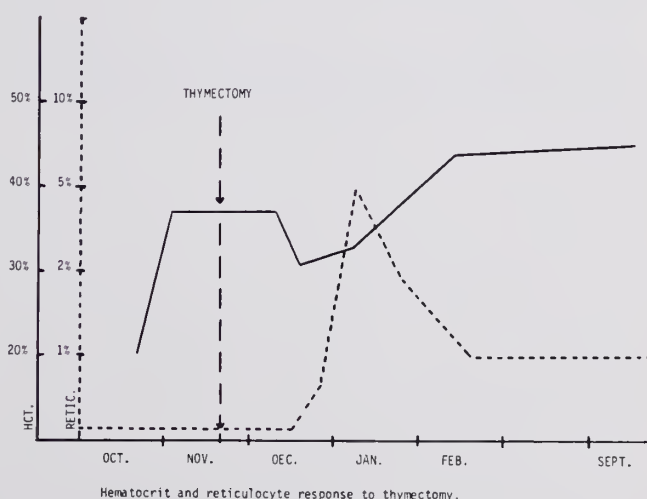


Fig. 4. — The clinical response to thymectomy. Of special interest is an approximate six week delay in significant reticulocytosis.

In summary, PRCA may occur in its secondary form as a consequence of multiple chronic and acute disorders. Correction of the underlying disorder usually results in permanent remission of the anemia. The primary or more chronic form of PRCA frequently is associated with immunologic abnormalities or diseases characterized by immunologic abnormalities. Adults presenting with PRCA should undergo appropriate clinical studies to rule out the presence of an underlying thymoma. The association of PRCA and thymoma

remains unclear. Treatment of the primary form of PRCA with thymectomy and/or immunosuppressive agents offers a chance of cure or remission to a significant percent of these patients.

Acknowledgments

We are indebted to Carl Moore, M.D., Pasadena, Florida, for referring the patient; to King Smith, M.D., for radiologic interpretation; and to Carol Mayer for very helpful secretarial assistance.

References

- Polaves, S.H.; Lederer, M.: Recipient of Many Blood Transfusions, *JAMA* 95: 407-409, 1930.
- Hirst, E.; Robertson, M.B.: Syndrome of Thymoma and Erythroblastopenic Anemia: Review of 56 Cases Including 3 Case Reports. *Medicine (Baltimore)* 46:225, 1967.
- Jacobs, E.M.; Hutter, R.V.P.; Pool, J.L., et al.: Benign Thymoma and Selective Erythroid Aplasia of Bone Marrow, *Cancer* 12:47, 1959.
- Roland, A.S.: Syndrome of Benign Thymoma and Primary Aregenerative Anemia: Analysis of Forty-three Cases, *Am. J. Sci.* 247:113, 1964.
- Schmid, J.R.; Kiely, J.M.; Harrison, E.G., et al.: Thymoma Associated with Pure Red-Cell Agenesis, *Cancer* 18:216, 1965.
- Al Mondhry, Zanjani, E.D.; Spivack, M., et al.: Pure Red Cell Aplasia and Thymoma: Loss of Serum Inhibitor of Erythropoiesis Following Thymectomy, *Blood* 38:576, 1971.
- Krantz, S.B.: Pure Red Cell Aplasia, *NEJM* 291:345, 1974.
- Krantz, S.B.: Diagnosis and Treatment of Pure Red Cell Aplasia, *Med. Cl. N Am.* 60:945, 1976.
- Krantz, S.B.; Kao, V.: Studies on Pure Red Cell Aplasia. I: Demonstration of Plasma Inhibitor to Heme Synthesis and Antibody to Erythroblast Nuclei, *Proc. Nat. Acad. Sci.* 58:493, 1967.
- Krantz, S.B.; Kao, V.: Studies on Pure Red Cell Aplasia. II: Report of Second Patient with Antibody to Erythroblast Nuclei and Remission After Immunosuppressive Therapy, *Blood* 31:1, 1969.
- Krantz, S.B.: Studies on Pure Red Cell Aplasia. III: Treatment with Horse Antihuman Thymocyte Gamma Globulin, *Blood* 39:347, 1972.
- Broman, F.P.; Freedman, M.H.; Blajchman, M.D.; McBride, J.A.: Complement Independent Erythropoietic Inhibitor Acting on Progenitor Cell in Refractory Anemia, *Am. J. Med.* 61:572, 1976.
- DeSevilla, E.; Forrest, J.V.; Zivnuska, F.R.; Sagel, S.S.: Metastatic Thymoma with Myasthenia Gravis and Pure Red Cell Aplasia, *Cancer* 36:1154, 1975.
- Zeok, J.V.; Todd, E.P.; Dillon, M., et al.: Role of Thymectomy in Red Cell Aplasia, *Ann. Thor. Surg.* 28:257, 1978.
- Marmont, A.; Peschle, C.; Sanguineti, M.; Condorelli, M.: Pure Red Cell Aplasia (PRCA): Response of Three Patients to Cyclophosphamide and/or Antilymphocyte Globulin (ALG) and Demonstration of Two Types of Serum IgG Inhibitors to Erythropoiesis, *Blood* 45:247, 1975.
- Peschle, C.; Marmont, A.M.; Marone, G., et al.: Pure Red Cell Aplasia: Studies on IgG Serum Inhibitor Neutralizing Erythropoietin, *Br. J. Haem.* 30:411, 1975.
- Meyer, R.J.; Hoffman, R.; Zanjani, E.D.: Autoimmune Hemolytic Anemia and Periodic Pure Red Cell Aplasia in Systemic Lupus Erythematosus, *Am. J. Med.* 65:342, 1978.
- Resegotti, L., et al.: Paraproteinemic Variety of Pure Red Cell Aplasia: Immunologic Studies in One Patient, *Acta Haematol. (Basel)* 60:227, 1978.
- Steinberg, M.H., et al.: Diamond-Blackfan Syndrome: Evidence for T-cell Mediated Suppression of Erythroid Development and Serum Blocking Factor Associated with Remission, *Br. J. Haem.* 41:57, 1979.
- Wintrobe M.W., et al.: Pure Red Cell Aplasia, *Clinical Hematology*, 7th. edition, 1969, 1974.
- River, G.L.: Erythroid Aplasia Following Thymectomy-Report of Case with Positive Lupus Erythematosus Cell Preparation and Elevated Plasma Erythropoietin Level, *JAMA* 197:726, 1966.
- Dameshek, W.; Brown, S.M.; Rubin, A.D.: "Pure" Red Cell Anemia (Erythroblastic Hypoplasia) and Thymoma, *Sem. Hemat.* 4:222, 1967.
- Hamilton, C.R.; Conley, C.L.: Pure Red Cell Aplasia and Thymoma, *Johns Hopkins Med. J.* 125:262, 1969.
- Murray, W.D.; Webb, J.N.: Thymoma Associated with Hypogammaglobulinemia and Pure Red Cell Aplasia, *Am. J. Med.* 41:974, 1966.
- Jepson, J.H.; Gardner, F.H., et al.: Gamma Globulin Inhibitor of Erythropoiesis in Erythroblastopenic Plasma from Patients with Thymoma, *Clin. Res.* 16:536, 1968.
- Keller, A.R.; Hochholzer, L.; Castleman, B.: Hyaline-Vascular and Plasma Cell Types of Giant Lymph Node Hyperplasia of Mediastinum and Other Locations, *Cancer* 29:670, 1972.
- Burgert, E.D.; Gilchrist, G.S.; Fairbanks, V.F., et al.: Intraabdominal, Angiofollicular Lymph Node Hyperplasia (Plasma Cell Variant) with Antierythropoietic Factor, *Mayo Clin. Proc.* 50:542, 1975.

• Dr. Rubio, 701 Sixth Street South, St. Petersburg 33701.

Pessaries and Prolapse

Thomas A. Rodenberg, M.D.

Abstract: The relative safety of modern day surgery permits various vaginal plastic and other reparative procedures with a certain amount of impunity. However, the old-fashioned pessary still has a role in the treatment of gynecological conditions. Unfortunately, it is no panacea and drawbacks do exist.

Two principal indications for use of a pessary are prolapse and/or retrodisplacement. It is more or less a temporary expedient when circumstances prevent immediate surgical repair such as when the patient's life expectancy is short, physical status is such as to contraindicate surgery, or she resists the opportunity to have surgical correction of the condition.

Women have been plagued since time immemorial by "falling of the womb" and other associated hernias. Today it is lightly assumed that surgery can correct these herniations and that such surgery is the best cure for prolapse.¹ Accordingly, the means of treatment have been divided into two classes, palliative and curative, with the pessary or intravaginal support being in the first category and surgery in the second.

As late as the mid-19th century major vaginal surgery was the equivalent of a death sentence for many. Naturally gadgets, contrivances and instruments of many kinds were designed and constructed in order to avoid such surgery. In ancient times the instrument was known as a pessus or pessarium. The composition varied from sea sponges to wood, ivory, rubber, metal frames, fabric, whalebones, and gutta percha.

Indications

Gynecological indications for utilization of pessaries have been multiple. Backache, hypemenorrhea and dysmenorrhea are everyday complaints. While orthopedic problems are the most common causes of backache, endocrine dysfunction the usual cause of abnormal uterine bleeding, and emotional difficulties a common cause or component of painful periods, uterine

displacement can also cause the problems. Here, a pessary can be employed as a diagnostic tool and may aid in clarifying the situation.

Actually, the pessary originally was designed to support uterine and/or vaginal prolapse. Even though surgery, anesthesia and associated medical knowledge have been advanced to the degree where operative correction of pelvic herniae can be afforded to many poor risk patients, the original use of the pessary remains. It can be used temporarily for patients with medical problems. There is a rather large group of elderly women who are very poor surgical risks due to cardiac and/or renal disease, diabetes, history of malignancy, etc., and there is a group who refuse the opportunity for surgery for reasons of their own.

There is a group picturesquely described by Novak as "pessary addicts." These patients derive a psychological rather than a uterine uplift from this little implement tucked away in the vagina.² Colmer, along the same lines, has referred to the "placebo function" of the pessary.³ Whether use in such a situation is a misapplication of mechanical function is an interesting matter of judgment.

In general, plastic surgical procedures for the correction of genital organ prolapse have been employed with success for only about the past 70 years. Differences of opinion about which specific tissues were responsible for support of pelvic organs have long existed. Most vaginal plastic or reparative procedures strongly resemble each other. There have been numerous adjustments and modifications of operations but the end results remain similar.

The restoration of function and alleviation of symptoms occur in about 80% of surgically treated patients. Unfortunately, as time goes on the number of

The Author

THOMAS A. RODENBERG, M.D.

Dr. Rodenberg is Clinical Associate Professor of Obstetrics and Gynecology at the University of Miami School of Medicine, Miami. This paper was presented at the Third Annual Meeting of the William A. Little Obstetrical-Gynecological Society, Fort Lauderdale, May 15-17, 1981.

patients with persistent good results gradually decreases. Genital organ prolapse tends to recur. Unfortunately, and far too often, the final result is a distorted vagina and return of symptoms. Thus, surgery cannot be considered a panacea.⁴

So, recognizing that the relative safety of modern day surgery permits the performing of various vaginal reparative procedures with a certain amount of impunity, the old-fashioned pessary still has a role in the treatment of various gynecological conditions. Unfortunately, it like surgery cannot be considered a panacea. Generally it is more or less a temporary expedient but in many older ladies temporary is long enough.

Procedure

Before considering the various pessaries, there is a basic philosophy which must be embraced, both for the good of the patient and the protection of the physician. The relationship between the two is a semipermanent one. The physician must consider the patient as being under his active care so long as she wears the device he has inserted.⁵ She must report periodically for removal of the pessary, inspection of the vaginal tissues and mucous membranes, cleansing of the pessary and possible reinsertion. The physician can be faulted if he fails to demand frequent return visits—not only for pessary cleansing but also for evaluation of the patient and for providing such treatment as may be indicated.⁶ There must be no uncertainty as to whether the patient will return at frequent intervals, as instructed.⁷⁻⁹

If a patient is so irresponsible or so infirm that she cannot return for follow-up visits and has no relative or attendant who will assume this responsibility, a pessary should not be used regardless of how satisfactorily it corrects the prolapse.

The first visit after the insertion of what appears to be the proper pessary should be in one week and not longer than two.¹ At this time, if the patient is comfortable, the position of the pessary and the uterus is checked again. On the first or second re-examination it may be necessary to refit with another pessary of different size or even with one of different configuration. This and follow-up re-examination represent standard technique in all pessary fittings.

If all is well, the patient is asked to return at regular intervals so that, as previously mentioned, the vaginal mucosa may be inspected, position of the uterus checked and the pessary removed and cleansed. The pessary then is either left out for a short period of time if the vaginal walls are irritated or reinserted if there is no contraindication.

If vaginal irritation is present, the pessary should not be reinserted for at least one week.⁵

This interval of pessary and vaginal reinspection varies; recommendations regarding the length of time a pessary may remain in place between examinations vary from one month to six to eight weeks, to three months.¹⁻¹⁰

Admittedly, a regimen of this sort is a nuisance. Suggestions have been made recommending patient education regarding a "do-it-yourself" routine in the removal, cleansing and replacement of the pessary. To provide office instruction undoubtedly will be time consuming and, quite likely, nonproductive. Many telephone calls at all hours of the day and night—from the patient, her family, and frequently from a hospital emergency room—must be expected. Unfortunately, patient resentment rather than gratitude will be the result.

Instrument Types

The choice of a pessary is of considerable importance. A ring pessary probably is most suitable for the majority of older patients. It tends to take up slack in the vagina as well as form a kind of cradle under the cervix. It has the added advantage of not interfering with performance of normal function and intercourse can be carried out satisfactorily. It is introduced edgewise and then turned so that the ring lies crosswise in the vagina. However, it may be of little use when the patient has an accompanying cystocele.

The Gelhorn pessary, a firm plastic device with the configuration of a mushroom, is more efficient in the patient with a tissue relaxation and a greater degree of herniation. Again, the need for its removal and cleansing at regular intervals must be emphasized. The Blair modification is a hole through the stem to permit drainage.

The Gehrung is a multiple purpose pessary which, in many instances, will not only support a cystocele but also will thin out a rectocele. It is of considerable value in third degree prolapse and may be tried in cases of severe prolapse not amenable to the previously mentioned pessaries, particularly where the cystocele slips out beside them. When properly placed it usually gives effective support and yet does not interfere with normal functions or with coitus. The introduction and satisfactory adjustment require considerable study and experience. As a result, it is rarely used.

An inflatable pessary is available in four sizes and consists of an inflatable and deflatable ball with an air valve operation. Insertion is effected in the deflated state and inflation then achieved by a ball. Supposedly, this too can be inserted and removed by the patient. Another pessary, the cube pessary, is particularly suited for third degree prolapse. It appears to offer unique and effective

support even in those cases combined with a rectocele and/or cystocele. The support is due to the suction action of the six concave surfaces that are self-positioning upon insertion. The moist vaginal mucosa invaginates into the concavities and by slight negative pressure holds the prolapse and keeps the vaginal wall from collapsing. This may, in certain instances, be suitable for patient self-care. She may do this by applying lubrication, compressing the pessary, and then inserting it well up into the vagina. In order to remove it, she breaks the suction with her finger, then grasps the pessary, compresses it and withdraws it.¹¹

Excessive vaginal secretions may be overcome and drainage permitted by burning a small hole in the center of the concavities.

Many other pessaries are available; however, these described would appear to be sufficient for all practical purposes.

The pessary should fit snugly but not tightly. It should not be used when acute or subacute inflammatory disease is present, there is inability to replace the uterus in an approximately normal position, force is necessary for its insertion, or discomfort is associated with its use. Continuing vaginal discomfort or dysuria after its insertion indicates that the instrument either is too large, improperly shaped or has changed position.

As mentioned previously, the regimen of removal, cleansing and replacement is a nuisance. In these situations priorities must be established.

Despite occasional removal of the instrument for cleansing, etc., continued wearing is invariably followed by irritative trauma to the vaginal epithelium, especially where there is pasty-thin postmenopausal vagina.

Severe vaginitis or cervical infection militate against usage of a pessary. In many instances this can be overcome with selected vaginal toilet and/or the judicious use of an estrogenic vaginal cream.

Another problem which may be encountered is the difficulty in reading vaginal smears in patients wearing a pessary. This is due to the associated acute inflammation in the vagina of many patients. Thus, it would be best to remove a pessary several days before attempting a PAP smear.¹²

The abandonment of the inserted vaginal pessary can lead to quite serious problems. Intravaginal strangulation of a prolapsed uterus through a ring pessary has been reported.⁵

There are other reported complications such as carcinoma, cellulitis, peritonitis and fistulae.^{1,13}

Undue prolonged irritation need not be a valid reason for discontinuance of the application of a pessary, however, it does demand biopsy. Further utilization of a pessary will depend then on the pathologist's report and the reparative powers of the injured vagina or cervix.

In summary, the pessary does have a definite place in the armamentarium of the gynecologist. It is a tool or crutch to be employed in the treatment and alleviation of prolapse in the unfortunate lady whose life expectancy is short, when her physical condition contraindicates surgery, or when she resists the opportunity to have surgical correction of the condition. The result invariably, and with only an occasional exception, will be a patient who not only will be able to resume the activities of a normal active existence but will be extremely happy and gratefully sing your praises.

References

1. TeLinde, R.W.: *Operative Gynecology*, 2nd ed. J.B. Lippincott Co., 164, 1957.
2. Novak, Emil: *Obst. Gynec. Survey* 3:267, 1948.
3. Colmer, W.M., Jr.: *Am. J. Obst. Gynec.* 65:170, 1953.
4. Dupre, R.B.: *Management of Genital Organ Prolapse*, *Clinical Ob. Gyn.*, Vol. 9, #4, 99.
5. McElin, T.W. and Paalman, R.S.: *Pessary Complications in Management of Uterine Prolapse*, *Am. J. Obst. Gynec.* 64:3, 1959.
6. Brewer, J.I.: *Textbook of Gynecology*, Ed. 2, Williams & Wilkins Company, Baltimore, 742, 1958.
7. Novak, Emil: *Gynecology and Female Endocrinology*, Little, Brown & Company, Boston, 243-252, 1941.
8. Novak, Emil: *Obst. Gynec. Survey* 3: 267, 1948.
9. Novak, Emil: *Obst. Gynec. Survey* 4: 313, 1949.
10. Parsons, L. and Sommers, S.C.: *Gynecology*, W. B. Saunders Co., Philadelphia, 10: 1, 1962.
11. Crossen, R.J.: *Diseases of Women*, Ed. 10, C.V. Mosby Co., St. Louis, 388, 1953.
12. Christ, M.L. and Haja, J.: *Cytological Changes Associated with Vaginal Pessary Use*, *Acta Cytol.* 22:146, 1978.
13. Curtis, A.H. and Huffman, J.W.: *Textbook of Gynecology*, Ed. 6, W. B. Saunders Co., Philadelphia, 330, 1950.
14. Russell, J.K.: *Dangerous Vaginal Pessary*, *Brit. Med. J.* 159: 1497, 1961.

• Dr. Rodenberg, 3816 Hollywood Boulevard, Hollywood 33021.

**REINSURANCE
BROKERS for
Florida Physicians
Insurance Reciprocal
—serving physicians
throughout Florida**



**The
Wetzel
Company,
Inc.**

P.O. Box 66452 · Houston, Texas 77006



SPECIAL ARTICLE

The House of Medicine:

Focus on the American Medical Association

Charles Donegan, M.D.

What Has the AMA Done for You?

One frequently hears a physician make the statement, "Why should I join the AMA, it has done nothing for me." No statement reflects more clearly the lack of understanding or interest in the AMA's role. The AMA has played a significant role in our lives from the day we entered medical school, by its participation in setting the high standards of both the medical schools we attended and the internship and residency training programs we experienced. The AMA has been deeply involved with the specialty organizations in establishing specialty boards, as well as requirements for certification in one's specialty.

The AMA is involved in the study and evaluation of all aspects of medical education and continuing medical education. Programs approved by the House of Delegates are being developed to insure the provision of a continuing supply of well-qualified physicians to meet the medical needs of the public. The AMA also provides the same services for the allied health professions.

The AMA reviews the social and economic aspects of medical care, and on behalf of the public and the profession, suggests means for the timely and equitable development of services in a changing socioeconomic environment. It confers with state constituent medical associations, component societies and national medical specialty societies regarding the status of anticipated proposals that would affect medical care.

Moreover, the AMA has been a compelling force in the continuous battle against overwhelming odds to preserve our free enterprise pluralistic health care system. This has without doubt insured Americans the highest quality health and medical care in the world.

This alone should make all physicians firmly committed to the goals and objectives of organized medicine at all levels, including the AMA.

Although since November 1980, our government has become more conservative, we will still see many changes in Medicaid and care of the poor and will continue to need strong national leadership in legislation.

Organized medicine needs your membership, participation and involvement. Today, only about 50% of the practicing physicians belong to the AMA. We should be 100% strong!

The Author

CHARLES DONEGAN, M.D.

Dr. Donegan is a practicing internist in St. Petersburg and is a member of the American Medical Association House of Delegates.

Is the AMA a Democratic Organization?

There appears to be a fairly widespread misconception especially among the younger doctors, that the practicing physician does not have input into the AMA.

At the present time, Florida has seven delegates to the AMA House of Delegates who represent the entire FMA membership even though there are only approximately 7,000 of the FMA's almost 14,000 members who also belong to the AMA. (The allotment of delegates from each constituent state association is one delegate for each 1,000 AMA members, or a fraction thereof, as recorded in the office of the Executive Vice President of the AMA on December 31 of each year.) Each delegate is elected for a two-year term by the members of the House of Delegates of the constituent society, in our case by the FMA House of Delegates.

To be eligible for membership in the House of Delegates, a physician must have been an active member of the AMA for two years immediately preceding the meeting of the House in which the member is to serve.

Presently, the AMA House of Delegates is made up of 283 delegates, of which 56 are representatives of their respective specialty societies. The House of Delegates meets twice a year, in June and December, to establish the policies of the association. These policies are then carried out by the fifteen member Board of Trustees.

A county medical society may send a proposed resolution to the AMA House of Delegates by way of the Florida Medical Association any time it wishes to suggest a change in existing policy or propose new policy. Any voting delegate of the AMA may submit a resolution to the AMA House of Delegates.

The House of Delegates of the American Medical Association is a democratic group made up of physicians with philosophical leanings ranging from very conservative to very liberal. Probably the majority are middle-of-the-roads.

All issues brought before the House of Delegates are debated before reference committees, as in the Florida House of Delegates, and any member of the AMA may appear before the committee to give his or her views and recommendations on any issue. The reference committee submits its recommendations to the AMA House of

Delegates and the issues may be debated again, if necessary, before the House prior to the vote.

Decisions occasionally are made by a one-vote majority or, not infrequently, by just a few votes. The House of Delegates in December 1980, voted 104 to 100 to encourage elimination of all federally controlled peer medical utilization review programs. It reiterated the AMA position to continue professionally directed efforts toward ensuring that care provided to patients is of high quality, appropriate duration, and rendered in a suitable setting at a reasonable cost. The Florida delegation unanimously supported the resolution, as directed by the Florida House of Delegates. Had our delegates voted on the other side, the resolution would have been defeated.

The national health insurance policy (Resolution No. 62) is an unaltered policy introduced by the FMA in December 1978. It took many hours of discussion and debate before it was successfully approved. Resolution No. 62 has withstood all challenges at subsequent House of Delegates meetings.

Every physician who is a member of the AMA has both the right, and the responsibility, to make constructive criticism of the AMA. However, non-members have no right to criticize the national leadership given us by the AMA, for it is indeed a real functioning democracy.

The New AMA

The AMA House of Delegates and the Board of Trustees have become more and more concerned about the decreasing percentage of physicians who have maintained their membership in the AMA.

At the same time, inflation through increasing costs has made it necessary to re-examine the functions, activities and resource needs of the AMA to keep it a highly viable organization meeting the needs of American medicine.

Approximately one year ago, the Board of Trustees instructed staff to develop a series of options for the House of Delegates as it considers AMA dues for the next few years. I will not go into all the details; however, two independent studies were conducted. One study reviewed AMA functions, activities, and resource needs; while the other reviewed AMA membership trends, physician response to previous dues increases, and physician attitudes. Recommendations to the House of

Delegates were based on a synthesis of the two sets of findings.

The analysis of the AMA functions, activities and needed resources began with a critical examination of the often stated premise that "If AMA disappeared today, someone would have to establish a new one tomorrow." In addressing that premise, no assumptions were made regarding current AMA policy and programs. Hence, the analysis is based on what functions a "new AMA" would perform in light of the current and future expected environment.

This analysis examined two levels of activity for the "new AMA": a minimal level that allows AMA to be responsive to its most fundamental functions, and a recommended level allowing AMA to provide more services and be more responsive to member needs and expectations. Both options resulted in considerable changes in emphasis and a substantially modified program configuration for AMA.

The critical analysis of the question of whether AMA would have to be recreated tomorrow if it disappeared today resulted in an affirmative answer based on an assessment of the needs of the profession and an analysis of what organizations can, and should, be responsible for filling these needs. This analysis led to the identification of a set of basic functions of the AMA.

II. Secondary Functions

- A. Training
- B. Provide membership benefits

III. Necessary Functions

- A. Maintain organizational strength
- B. Administration and management

The "new AMA" organizational structure was adopted by the House of Delegates at their Chicago meeting in June 1981. In order for it to attain the success we wish for organized medicine, we must have the support of the practicing physicians, including those in the State of Florida, and be as effective at the national level as the Florida Medical Association is on the state level.

- Dr. Donegan, 501 11th Street North, St. Petersburg 33705

I. Primary Functions

A. Representation

1. Single most important function of AMA; to be most prominent function of newly redefined AMA.
2. Policy development in scientific and medical education and socioeconomic arenas.
3. To government agencies at all levels, business community, labor, other professions, general public.
4. Out in front with a position and/or with information when needed.

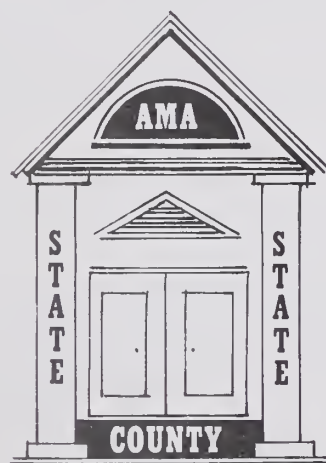
B. Provide information

1. General scientific-medical
2. Socioeconomic-political
3. Data established in the medical profession.

C. Establish, maintain and implement standards of conduct and performance.

D. Maintenance and implementation of educational standards. (A primary function but responsibility is shared with other organizations.)

The "House of Medicine"...



Needs Your Support

Membership: It's a Question of Dollars and Sense

J.H. Sammons, M.D.

Throughout my career in medicine both as a practicing physician and a medical association executive, I have heard my colleagues express concern over the cost of membership dues. Frankly, those are feelings that I have a hard time understanding, not because the cost of dues isn't a concern to me, but because I believe we've been wrongly focusing on considerations of price rather than of value.

Economists frequently use the term "cost-benefit ratio" when talking about the price of an item or service in relation to its value. That's the way we should be looking at membership dues. I truly believe that membership in organized medicine would withstand any cost-benefit analysis we could conduct, with the benefits far exceeding the cost.

I'm not referring merely to the tangible benefits of membership, although they're certainly numerous and diverse from publications such as this *Journal of the Florida Medical Association* that you're reading, JAMA, AM News, specialty journals; educational seminars and workshops, insurance programs, to special services provided by your county medical society.

All are significant benefits provided by our federation, but I believe the real value of membership lies in other areas — areas not so easily defined. To assess membership's true value, we should be asking ourselves questions like these:

1. What is it worth to have our rights and interests represented in our local and state legislatures as well as in Congress?
2. What is it worth to have our colleagues, rather than the government, define and monitor the standards for medical training and medical care?
3. What is it worth to have a representative forum in which we, along with our colleagues across the

country, can raise and argue issues, reach a consensus, and formulate policy in diverse areas of medicine?

4. What is it worth to have a strong, unified voice of American medicine? To enable your colleague or medical association executive giving testimony before the Florida Legislature or the United States Congress to say, "Yes, I represent *all* the physicians in Florida."

Were we able to place a dollar value on these means of preserving our rights as professionals, I believe you'd agree that the figure would far and away exceed the cost of our dues.

Let's take a look at it. I realize that your combined membership dues bill (county, Florida Medical Association, and AMA) can run over \$600 per year, and that's a sizable amount; but as you know, those dues are tax-deductible. For most of us, the net cost is approximately 50% of the original figure. For those of you who are just beginning a practice, are salaried faculty members, or are slowing down your practice, the net price of full membership in organized medicine may be slightly more. But in either case, the benefits outweigh the cost.

In the final analysis, you must decide whether you can afford to join the three levels of organized medicine. My guess is that you can afford it. My question to you is: Can you afford not to?

- Dr. Sammons, AMA, 535 North Dearborn Street, Chicago, Ill 60610

The Author

J. H. SAMMONS, M.D.

Dr. Sammons is the Executive Vice President of the American Medical Association.

ORGANIZATION

Summary of the FMA Board of Governors Meeting October 7-8, 1981

The following is a summary of the major actions taken by the Board of Governors at its meeting October 7-8, 1981.

THE BOARD:

1982 Budget

The Board reviewed the FMA Financial Statement and proposed Budget presented by the Treasurer, Executive Vice President and Executive Director. It was noted that anticipated income for 1982 would increase as a result of the dues increase approved by the 1981 House of Delegates from \$175.00 to \$225.00 for active members effective January 1, 1982. Approximately 50 percent of the additional income was budgeted to reserves to insure that the increased income would not be depleted by expenditures during the first year the dues increase becomes effective. The Board approved the Budget for 1982 with total anticipated income and expenditures in the amount of \$3,097,000.00.

FMA Special Committee on Management

The Board received a status report from the Special Committee on Management regarding the transition of management responsibilities of the Executive Vice President following the 1984 Annual Meeting as previously approved by the Board. The Board expressed satisfaction with the transition to date and directed that it be continued in an orderly and efficient manner.

AMA Awards

The Board expressed its sincerest commendation to Dr. Jean Jones Perdue of Miami upon her selection as the recipient of the AMA Benjamin Rush Award. The Board further voted its full support for the nomination of Dr. Joe Davis of Miami as the recipient of the AMA Distinguished Service Award.

FMA Awards

Excellence in Journalism:

Approved continuation of the Association's Excellence in Journalism Award for 1982 to recognize outstanding accomplishments by the news media related to medical topics.

Medical Speakers Award:

Approved the establishment of an FMA-sponsored Speakers Award to acknowledge exemplary medical speakers who have distinguished themselves via the electronic media and before live audiences.

Medical Malpractice Prevention Award:

Approved establishment of a Medical Malpractice Prevention Award to be sponsored by the Florida Physicians' Insurance Reciprocal to recognize physicians and other individuals who have distinguished themselves through activities relating to medical malpractice prevention.

The criteria for the newly established awards will be forwarded to all county medical societies.

Student Medical Association

Approved in principle the establishment of an FMA Student Medical Society subject to appropriate changes in the FMA Bylaws.

1982 Florida Relative Value Studies

Approved funds for publication of the Revised Florida Relative Value Studies in early 1982 with the first copy to be provided to FMA members at no charge as part of their dues.

The Board rejected inclusion in the RVS of qualifying circumstances for anesthesia 99100 and 99135 from page 50 of Current Procedural Terminology, Fourth Edition (CPT-4).

The Board further directed that there be no differential units for high risk factors for specialty groups.

FMA-Sponsored Insurance Programs

Approved changes in the FMA-sponsored insurance programs including:

• Retired Lives Reserves:

A retired lives program to provide group term life insurance to age 100 using a reserve account built up over the years of the program to continue term insurance after age 70. The reserve account can be funded from tax deductible contributions if the practice is incorporated.

• Disability Income Program:

Establish a new disability income plan for physicians to improve the existing FMA-endorsed program. All new and present policy holders are eligible for a non-cancellable, guaranteed renewable policy up to \$5,000 per month. Other insureds, if rejected, may receive minimum coverage.

• AD&D Annuity Program:

A supplement to the existing AD&D program to pay the beneficiary in case of accidental death a lump sum settlement of \$12,000 and \$1,000 per month for life with 20 years certain paid to the estate.

FMIT Program

Approved modifications for improving the FMIT program to include:

- A conversion program for physicians and employees who leave the insured group.
- An option that the widow or widower may choose within thirty days after the death of the participant to remain on the billing of the group for either single or family coverage at the rate of the widow or widower's attained age. If the widow or widower remarries, they are no longer eligible.

Designation of Historical Sites/ Medical Museums

In accordance with the criteria approved by the House of Delegates at the 1981 Annual Meeting for designating an historical site or medical museum in Florida, the Board approved historical site designation for:

- The John Ropp House, Gainesville Alachua County Medical Society
- Old St. Lukes Hospital, Jacksonville Duval County Medical Society
- The Alamo, Miami Dade County Medical Association

- Dependent children who are over 19 and not full-time college students, and who are not married and are dependent upon the family for support, whether living at home or not, can be covered up to age 29 by the payment of a single premium per month. Full-time college students will be covered under their parents' policy until they graduate prior to age 23 or, if a full-time college student at age 23, must take a single rate after age 23.

- An increase in the maximum life insurance from \$50,000 to \$100,000. There are two options under the plan:

- Option 1: All those presently in the plan will be given the option without medical questionnaire to increase their life coverage at the new rates. Coverage will continue at the old rates at least until June 1, 1981.
- Option 2: Physicians joining the plan after September 1, 1981 will be given a new age-rated life program. If they place life insurance on 75% of the employees, there is no health questionnaire. If they do not wish to cover 75% of their employees, life insurance is only available subject to pre-underwriting by use of health questionnaire.

Detailed information regarding modifications in the FMA-sponsored insurance programs, including the FMIT, will be sent to all FMA members.

COUNCIL AND COMMITTEE REPORTS

Committee on Professional Liability

The Board reviewed the report and recommendations of the Committee on Professional Liability established by the Board to review the current status of professional liability in the State of Florida as it affects the medical profession and specifically members of the FMA.

The Board approved the report in principle for implementation as feasible and requested that the entire report be published in *The FMA Journal* for the information of the membership. A copy of the PLI Committee's report is published elsewhere in this issue of *The Journal*.

The Board commended the representatives of the Florida Physicians' Insurance Reciprocal (FPIR) and the Professional Insurance Management Co., (PIMCO) for the excellent risk management programs that have been conducted in county medical societies throughout the State.

Council on Legislation 1982 Legislative Priorities:

Approved initial priorities for the FMA 1982 Legislative Program:

- Support efforts to sustain Governor Graham's veto of the I.A.T. bill (CS/SB 747) the unorthodox Cancer Treatment bill and requested the President to send a letter to all FMA members urging that they contact their individual legislators to seek their support for sustaining the Governor's veto and further that the FMA's position on the bill be widely disseminated through the news media.
- Sponsor legislation requiring filing of written protocols with the State Board of Medical Examiners and appropriate physician supervision for Advanced Registered Nurse Practitioners.
- Endorse legislation requiring safety restraints in motorized vehicles for children under age 4.
- Sunset review of the State Insurance Code and Hospital Licensure Law.
- Oppose the use or prescribing of drugs by optometrists in treating disease.
- Oppose state funding of HSA's.

Council on Health Care Financing

- Oppose access to hospital staff privileges or facilities for chiropractors.
- Oppose future state funding of the School of Osteopathy in Florida.

Public Health Training Programs:

Expressed support for the concept of expansion of current training programs for public health professionals.

Block Grants:

Directed that the FMA make every effort to insure that state administered health programs receive the highest level of funding possible.

Medicine and Business Coalitions:

Endorsed the concept of physicians initiating the formation of and participation at a policy-making level of local medicine and business coalitions.

Chambers of Commerce:

Encouraged county medical societies to actively participate in their local Chambers of Commerce.

Florida Physicians Association:

Requested the Florida Physicians Association to investigate efforts of the Office of Medicaid Fraud and Abuse to recover retroactively alleged over-payments for office visit charges to physicians and report its findings to the Board.

Low Energy Assistance Program:

Requested that the FMA Judicial Council review the forms required by the Department of HRS for the low energy assistance program as to the legal and ethical liability of physicians in filling out these forms. The Board further requested that contact be made with the Secretary of HRS and that he be requested to insure that the application for low energy assistance include all provisions of the federal law.

PMUR:

The Board endorsed the continuation of county medical societies' participation in peer medical utilization review for Medicare and authorized negotiations for continuing the PMUR contract for Medicare with Blue Cross and Blue Shield based on a drastically reduced

budget allocation due to federal cut-backs in funding. The Board further approved revision of the procedures under which the PMUR program operates.

Council on Specialty Medicine

Specialty Group Legislative Guidelines:

Adopted guidelines for legislative activities for FMA-Recognized Specialty Groups to insure the coordination of specialty group legislative objectives with those of the FMA.

Council on Medical Services

Measles Eradication Campaign:

Adopted a resolution in support of the national campaign to eradicate measles:

WHEREAS, The Center for Disease Control (CDC) Measles Elimination Initiative has been very successful to date in dramatically decreasing measles transmission; and

WHEREAS, The maintenance of high immunization level, comprehensive K-12 school immunization laws with exclusionary provisions, and the surveillance and control of outbreaks have been a mainstay of the elimination initiative; and

WHEREAS, Florida is one of the few remaining areas of measles endemicity in the United States; therefore be it

RESOLVED, That the FMA support the combined efforts of the Department of Health and Rehabilitative Services and the Department of Education in the implementation of the new school immunization law and that DHRS/DOE launch a Florida measles elimination initiative.

Look-Alike Drugs:

Voted to express to the State Attorney General FMA's concern about the unsolicited direct mail advertisements in Florida on look-alike drugs with the request that he determine if some controls on this type of advertising can be established.

Judicial Council

Reviewed recent Opinions issued by the Judicial Council in response to specific ethical inquiries:

Impaired Physicians:

It is the Opinion of the Judicial Council that every physician is ethically bound to assist a colleague who is perceived to be

impaired. It is further the Opinion of the Council that there are a variety of mechanisms available to appropriately meet the various situations of impairment, including, but not limited to, the Florida Medical Foundation program for impaired physicians.

Interest on Unpaid Bills:

It is the Opinion of the Judicial Council that it is not in the best interest of the public nor the profession to charge interest on an unpaid bill, nor charge a penalty on fees for professional services not paid within a prescribed period of time.

Service Charges on Unpaid Accounts:

It is the Opinion of the Judicial Council that a physician may ethically charge a service charge for re-billing an unpaid account, provided that the physician has closely scrutinized the time frame for such re-billing as to its reasonableness and that the charge for such re-billing reflects, as closely as possible, the actual expense.

Physician/Patient Contracts:

It is the Opinion of the Judicial Council that it is not ethical for a physician to require a patient to sign a contract or agreement that provides that the patient shall pay legal fees and court costs should legal action be required to collect a past due account of the patient.

Misleading Advertising:

It is the Opinion of the Judicial Council that a Doctor of Osteopathy would engage in deceptive and misleading advertising if he listed himself under the "M.D. Section" of the telephone page directory, in that such listing would be incorrect and contain incomplete facts or representation or implications that are likely to be misunderstood or be deceiving and thus be in violation of the Florida Medical Association policy statement, Re: Advertising.

Approved recommendations for membership development in Florida including:

- That a standing committee of the Board of Governors be appointed to be composed of the FMA Secretary, Chairman of the AMA Delegation and Representatives from each of the four Florida Medical Districts and that this

Membership Development

committee be charged with the responsibility of on-going membership development and retention at all levels; and further that the committee carry out its functions in close cooperation with FMA component county medical societies and the AMA.

- That following the initial billing for dues payable on January 1, that on March 1 AMA dues statements be sent to all physicians who have paid their county and state dues, but who have not paid their AMA dues, along with a promotional message. That an additional promotional message and statement be sent to those physicians who have not paid by June 1.
- That periodic articles be published in *The Journal of the FMA* regarding AMA membership, as well as state and county medical society membership. The Board noted that in cooperation with the editor of *The Journal* the November cover of *The Journal* will

be dedicated to AMA membership. In addition, county medical societies are being urged to include articles on membership in the November or December issues of their county society bulletins.

- That consideration be given to the feasibility of unified membership in Florida.
- That a study be authorized to determine as accurately as possible the total number of physicians in private practice in Florida who do not belong to their county medical societies in order to determine if it would be feasible to attempt to bring these physicians into organized medicine.
- Requested that FMA component county medical societies make every effort to insure that physicians elected to serve in the FMA House of Delegates are members of the AMA.

Report of the FMA Committee on Professional Liability*

A review of the current status of professional liability in the State of Florida as it affects the medical profession and specifically members of the FMA.

Historical Background

1929-1952 The F.M.A. established a group program in 1929, with a master policy, issued by three major commercial insurance companies, in the United States. The group issued individual certificates, to individual physicians insured under the program. The records did not indicate any specific problems but did reveal a low utilization of the program due to the open market and ready availability of medical liability insurance in Florida during this period of time.

We can not ascertain any unusual activities regarding this program until after World War II when all three companies declined to continue the program and underwrite a group, i.e., the F.M.A. members.

1953-1962 The F.M.A. established a special committee in 1953 to review the professional liability problem which had developed in New York State and California and was beginning to develop in the State of Florida. (The committee was chaired by Dr. Robert E. Zellner of Orlando assisted by Dr. Sam Day, Secretary-Treasurer of F.M.A. and staffed by Harold Parham, P.R. and Legislative Director of F.M.A.) This committee developed and recommended to the Association, which adopted, a master professional liability program for the F.M.A. membership. Its format is currently in use today as it involved centralized claims handling, coordinated legal defense, peer underwriting and claims review by county medical societies. An attempt to market this program for approximately 10 years was made without any success.

1963-1972

In 1963, the London Agency of Atlanta was successful in obtaining the Employers Group of Insurance Companies of Boston to underwrite the F.M.A. group program, based upon the criteria adopted by the Association. This program experienced a very slow growth until the late 60's when a number of commercial carriers discontinued writing professional liability insurance in Florida.

The Commercial Union of England purchased the Employers Group of Insurance Companies in 1972 and directed that they terminate all physicians' medical liability insurance in the United States at year's end.

The two major groups, i.e., F.M.A. plan and the Illinois State Medical Association plan, were terminated at the end of 1972.

During this period of time, THE PREMIUM for a physician for \$100,000-\$300,000 occurrence insurance was:

Low: \$99

High: \$3,425

See Appendix I.

1973-1975

The F.M.A. in cooperation with the London Agency had developed outstanding statistical data regarding the F.M.A. Professional Liability Insurance Program. At that time the data was among the most complete in the United States as major insurance carriers had not segregated professional liability income and loss data from its other casualty business. A representative of the F.M.A. and of the London Agency explored the American market for a major insurance company to underwrite the F.M.A. Professional Liability Insurance Program effective January 1, 1973. After extensive work, three major companies agreed to underwrite the program: Chubb and Son of New Jersey (Federal Insurance Company), CNA (Continental of North America), and Argonaut Insurance Company of California. After considerable review, the Argonaut Insurance Company

*Adopted by the FMA Board of Governors, October 8, 1981

was selected to underwrite the program because (other things being equal) they agreed to quarterly payment of premiums. This quarterly payment proved to be unsatisfactory and was later changed to semiannual. The program thrived and insured almost 7,000 physicians (estimated at 85% of the potential market).

In early 1975, attorneys for the Teledyne Corporation, representing their subsidiary, the Argonaut Insurance Company, demanded major changes in the premium structure by the Argonaut Insurance Company for the F.M.A. plan which had been contracted for in December, 1974. They demanded a 300% increase and assessed every insured physician in Florida for an amount exceeding \$13,000,000, which was illegal, in violation of the insurance code, and resulted in the revocation of their license (which was never enforced). A lengthy, costly trial ensued and in the summer of 1975 a Federal Court in Jacksonville ruled that the continuing contract between the Argonaut Insurance Company and the F.M.A. could not be enforced because of the annual determination of rates; however, the Court did rule that the premiums and contract for the year 1975 must be honored by the Argonaut Insurance Company. The Court also required the Argonaut to refund to each individual physician the additional premium which it had illegally assessed. The premium for \$100,000-\$300,000 occurrence insurance during this period was:

Low: \$381 High: \$9,252

See Appendix I.

As a result of Teledyne's actions, Argonaut discontinued writing professional liability insurance in Florida which also terminated the coverage of the Florida Hospital Association group which insured over 30 hospitals and further added to the professional liability crisis in the State.

Mr. Bruce Woolery, President of Argonaut, who signed the contract with the F.M.A., after 24 years with the company, resigned as President and Chief Executive Officer along with 11 of the 12 senior officers due to their company being dishonored by its parent company, Teledyne. Mr. Woolery further assisted the F.M.A. during the trial

1975-1981

and has assisted the F.M.A. in its professional liability program ever since at a personal sacrifice of time and money.

The F.M.A. representative jointly with the representative of the London Agency, searched the entire American market and could not obtain any reputable commercial carrier to underwrite the group program of the F.M.A. effective January 1, 1976. The F.M.A. had inadequate resources to capitalize an insurance company in Florida. The F.M.A. leadership was faced with several alternatives:

1. Do nothing and allow Florida Legislature to resolve the matter, (which happened in some other states with very unsatisfactory results),
2. Soliciting funds from individual physicians to capitalize an insurance company for which it was believed there was inadequate time,
3. To utilize a unique Florida Statute which allowed the formation of a Trust with unlimited liability but limited application, i.e., professional liability indemnification.

The F.M.A. pursued the third option and in the summer of 1975 representatives of the F.M.A. in cooperation with the London Agency (specifically its President, Leyton Hunter), formed the F.M.A. Professional Liability Insurance Trust which became effective and began issuing coverage on December 1, 1975.

The Trust adopted the features of the previous F.M.A. Professional Liability program which were applicable and appropriate. A major change in indemnification was from occurrence coverage to claims made. It utilized the occurrence premium of the Argonaut program for occurrence coverage, but provided claims made coverage which allowed for approximately one-third of the premium to be utilized for surplus. Nearing the end of 1976 this surplus was released by each individual physician from his trust account and the Florida Physicians' Insurance RECIPROCAL was capitalized. The RECIPROCAL assumed all assets and liabilities of the Trust and further indemnified the Trust with insurance coverage for any future losses. The RECIPROCAL vehicle as

recommended by our advisers and reinsurers was adopted versus a mutual company in that it allowed more stability to the corporate structure, i.e., Attorney-in-Fact, Advisory Board, versus a mutual company with possible instability and lack of continuity of the Directors.

There was no major reinsurance facility available in the United States and the Reciprocal was required to go to Lloyds of London and other underwriters to obtain the reinsurance coverage. The reinsurers were insistent concerning the stability of the Board and management of the Reciprocal if they were to provide the reinsurance. The F.M.A. and the Trust made arrangements for the dissolution of HARLAN-MED, Inc., an insurance agency owned by the F.M.A. and Harlan interests, and to utilize those appropriate assets of HARLAN-MED, Inc. to form the Professional Insurance Management Company (PIMCO) as the managing agent for the Reciprocal and general insurance agency for other F.M.A. sponsored insurance programs. Originally, the F.M.A. owned 50% of PIMCO stock which was sold to the Reciprocal shortly after the program was stabilized. The premium for \$500,000 claims made coverage during this period is:

Low: \$814 High: \$14,612

The premium history of the Trust and the Reciprocal is shown in Appendix II.

The Legislative Arena

Due to the Professional Liability crisis in Florida which was REAL (rather than imagined as some have indicated), the leadership of the Florida Legislature adopted two major programs primarily to solve the problem of the Florida hospitals and those physicians not covered by the other programs: the Patient's Compensation Fund and the Joint Underwriting Association which required all casualty companies writing casualty insurance in Florida to provide Professional Liability Insurance coverage to physicians, hospitals, and others.

1. Medical Malpractice Joint Underwriting Association

The medical malpractice Joint Underwriting Association, consisting of all private

companies licensed to issue casualty insurance in the State, was created by the legislature in 1975. The purpose of the MMJUA is to provide coverage for claims arising out of the rendering or failure to render medical care or services and in the case of Health Care Facilities, coverage for bodily injury or property damage to the person or property of any patient arising out of the insured's activities in appropriate policy forms and for all other health care providers. The Plan provides coverage for Medical Doctors, Hospitals, Osteopaths, Podiatrists, Dentists, Chiropractors, Naturopaths, Nurses, Clinical Laboratories, Physicians Assistants, Physical Therapists, HMO's, Ambulatory Surgical Centers, and other medical facilities such as Blood Banks, Plasma Centers, and Renal Dialysis Facilities. During the 1981 Session of the Legislature, the temporary nature of the JUA was removed. It initially had been created for a period of three years and extended for an additional three years, prior to the removal of the temporary provision. The current premiums for the JUA are:

Low: \$2,570

High: \$38,990

2. Florida Patient's Compensation Fund

The Fund was created in 1975 to provide for medical malpractice and other specified tort recoveries for claims in excess of \$100,000.00. This fund may assess its members for excessive losses. Pursuant to this legislation, the personal liability of a health care provider being sued for injuries allegedly arising out of the rendering, or failure to render medical care or services, or for bodily injury or property damage to the person or property of any patient allegedly arising out of the health care provider's activities is limited to \$100,000.00 per claim or \$500,000.00 per occurrence. If at the time the incident giving rise to the cause of the claim occurred, the health care provider had paid its required fee to the Fund, defense for the Fund is provided. It is further provided that the health care provider pay at least the initial \$100,000.00 or the maximum limit of the underlying coverage, whichever is greater of any settlement or judgment against the health

care provider. In the Patient's Compensation Fund the term "health care provider" means essentially the same types of providers as mentioned in the above paragraph relating to the Joint Underwriting Association. The current premium for the Patient's Compensation Fund are:

Low: \$698 High: \$4,323

The F.M.A. in 1975 adopted an extensive short and long range program to assist and improve the Professional Liability climate in Florida in which its members were practicing medicine.

1. An overall public relations program which has been covered by other reports and will not be dealt with here.

2. A positive, aggressive Legislative program with many implications which brought forth opposition from many areas but primarily the plaintiffs' bar.

A summary of the Legislation sponsored by the F.M.A. and results both by the Florida Legislature and the Courts is as follows.

Status of Tort Reform Legislation Proposed by F.M.A.

Since 1975 the following legislation has been proposed by the F.M.A. and subsequently adopted by the Florida Legislature:

1. Establishment of Medical Liability Mediation Panels which provided for the filing, hearing and disposition of medical malpractice cases.
2. A major revision in the Statute of Limitations for medical malpractice claims. (Two-two and four years.)
3. Elimination of the Ad Damnum Clause.
4. Establishment of criteria for dealing with informed consent.
5. Structured payment of awards when the jury award for all future damages is \$200,000.00 or more.
6. Itemized verdicts.
7. Definition of similar health care provider.
8. Definition of medical professional negligence.
9. Application of collateral sources in jury trials as a direct off-set.
10. Elimination of the use of Res Ipsa Loquitor, except in cases involving foreign bodies.

11. Establishment of a remittitur-additur provision allowing adjustments by the Court of certain jury verdicts.

12. Adoption of the Recovery of Costs concept wherein the losing party must pay the attorneys' fees of the prevailing party in a medical malpractice action. We have been unsuccessful in our efforts to have legislation enacted which would:

1. Establish an absolute two year Statute of Limitations.
2. A limit on general damages.

Since 1975 the one major piece of legislation that has been impacted upon by a court decision was the loss of the Medical Mediation Panel Statute as a result of the decision of the Florida Supreme Court in February of 1980. Additionally, there has been a recent decision that diminishes the impact of the res ipsa loquitor statute. The F.M.A. is hopeful in getting that particular case reheard by the First District Court of Appeal, or, in the alternative, have the decision reviewed by the Florida Supreme Court.

Summary Judgments

Another concern to the F.M.A. leadership was the matter of Summary Judgments and its seesaw effect in Florida and its tremendous influence upon the cost of defense of professional liability suits.

The Summary Judgment procedure was adopted in Florida Civil Procedure in 1950. It was created by statute in some jurisdictions in the Nineteenth Century and received its impetus by incorporation in the federal rules of civil procedure. Florida Courts have followed a more restrictive course in the use of the rule than federal courts so that THE RULE HAS LOST MUCH OF ITS UTILITY IN FLORIDA practice.

The purpose of a Summary Judgment is to avoid the expense and delay of trial when no dispute exists concerning *material facts*. In all other procedural matters a trial court is presumed to act correctly and the appealing party must show not only error, but harmful error. In Summary Judgment appeals every attempt will be made by the

appellate court to reserve the Summary Judgment. The record is reviewed in the most favorable light toward the party against whom the Summary Judgment was entered. Defenses not raised by the losing party and almost any additional proof on a motion for re-hearing are examples of the length to which appellate courts have gone to reverse Summary Judgments in flat defiance of well settled principles of law for reviewing judgments.

The burden of showing that no genuine issue of material fact exists is on the moving party. This has always been so, but the standard by which the burden is measured has changed. In 1966 the Supreme Court of Florida rendered its decision in the case of *Holl v. Talcott*, a medical malpractice action. IN THIS CASE THE COURT CREATED A PRINCIPLE THAT THE MOVANT, THE INDIVIDUAL MOVING FOR A SUMMARY JUDGMENT, MUST CONCLUSIVELY ESTABLISH THE ABSENCE OF A MATERIAL FACT ISSUE. THIS DECISION PLACED A HEAVIER BURDEN ON THE MOVANT. THE DECISION IS WRONG AND ITS REQUIREMENT IS IMPRACTICAL. IT SHOULD BE OVER-RULED AND THE FORMER PRACTICE, WHEREIN THE MOVANT HAD TO PRESENT A *PRIMA FACIE* CASE BE RESTORED. The present burden is on the movant to establish conclusively that no material fact exists without a definition of "conclusive". The difficulty of applying this test will continue to plague the courts and medical malpractice defendants until it is changed.

In 1979, the Supreme Court went back to the earlier principle that the movant must initially show the non-existence of a genuine issue of material fact. Once the movant does so, the adverse party must show to the contrary to avoid summary judgment. The test applied was far less stringent than the conclusive showing required under *Holl v. Talcott*. However, the effect of this decision is still not being felt in medical malpractice actions.

Professional Liability Insurance Trusts

Individual groups of physicians outside of the purview and responsibility of the F.M.A.

formed several Professional Liability Insurance Trusts which are still in effect today. A review of the annual reports of these Trusts filed with the Florida Insurance Department appear as Appendix II.

Commercial Carriers

There has been no significant re-entry in Florida by commercial insurance companies except for the St. Paul Fire and Marine. This company re-entered the Florida market in 1980 with what this committee considers substandard rates which they will not be able to maintain over a period of years. The F.M.A. was unable to obtain any Florida data from the Florida Insurance Department which will justify the St. Paul rates as they used vague national figures.

Conclusions and Observations

The Florida Medical Association has:

1. Provided positive and aggressive leadership in producing both the availability and affordability of professional liability insurance in a stable and responsible manner.
2. Attempted to improve the climate in which physicians may practice medicine.
3. Monitored all major activities affecting professional liability.

Notwithstanding all the major activities of the F.M.A., its members, the auxiliary, the Governor, and the Florida Legislature, WE ARE FACED WITH THE ESCALATION OF ANOTHER PROFESSIONAL LIABILITY CRISIS IN THIS STATE.

The frequency and severity of claims continues to rise at an alarming rate; i.e., in 1963, 5.4% of the physicians insured were sued annually and the average cost per claim was \$4,138.00 with 100% of the claims closed. In 1980, this has exceeded 20% or one in five physicians per year with the average cost per claim exceeding \$23,000.00. Preliminary figures for 1982 place this in excess of \$33,000.00 per claim. The frequency of claims in excess of \$100,000.00 is also dramatic and alarming. The F.M.A. program experienced NO CLAIMS IN THIS AMOUNT PRIOR TO 1969 WHEN WE HAD TWO AND IS CURRENTLY IN EXCESS OF 100. (All these figures are based upon the Florida

Medical Association sponsored Professional Liability Insurance Program since 1963 and no other companies' data. This data bank consists of 10,324 closed claims with losses exceeding \$143,500,000.00.)

The professional advice made available to your committee indicates that the medical professional liability trusts formed by individual groups of physicians in Florida are currently financially questionable as to their stability but are assessable to their members during each policy year.

Your committee is also of the opinion that the Patients' Compensation Fund is actuarially unsound—short between 45 and 55 million dollars based upon the information presented to the Florida Legislature and will result in increased contributions (premiums) and/or raising the threshold of liability required for coverage.

Based upon the opinion of all five astute attorneys consulted by the F.M.A., it would be futile to attempt re-enactment of mediation panels due to the Florida Supreme Court decision. (Mathews, Horne, French, Fokes, Thrasher.)

The Joint Underwriting Association has proven to be actuarially sound and is contemplating a dividend or refund in premium. This being occurrence insurance, there will be a number of years before the final results are known.

The Reciprocal and PIMCO's extensive program of loss prevention and medical malpractice prevention seminars in Florida hopefully will have a favorable effect upon future experience.

Florida is still faced with:

1. A serious problem regarding bad faith demands by insured physicians willing to settle when there is lack of merit and when threatened by punitive damages.
2. Seesaw rules regarding Summary Judgments by the Judiciary.
3. Many, including this committee, are of the opinion that Professional Liability Insurance is being utilized to pay health, accident, disability, and life insurance benefits where no direct negligence exists and a premium has not been paid for this exposure.

4. This committee has observed no positive solution to the medical malpractice dilemma in the current social attitudes and judicial structure of our State.

Recommendations

1. That the F.M.A. continue:
 - a. An aggressive public relations program and attempt to educate the public regarding the seriousness of the medical professional liability problem; how it effects them both medically, surgically, emotionally, and financially.
 - b. An aggressive program directed to the public, the Legislature, and the judiciary of the current abuses of the contingency fee system with an attempt to drastically modify the current system to eliminate the abuses.
2. That the F.M.A. embark on a massive educational program directed to the public, the Legislature (at the appropriate time) and all appropriate parties with information and facts regarding the need of the Legislature to correct abuses of bad faith demands, punitive damages, summary judgments, a limit on general damages, pain, suffering and enforce the use of structured settlements.
3. That the Patient's Compensation Fund be made actuarially sound by the Legislature so as not to create another Professional Liability crisis in this program when it can be prevented.

RESPECTFULLY SUBMITTED:

*T. Byron Thames, M.D., Chairman
Vernon B. Astler, M.D.
Francis C. Coleman, M.D.*

*Committee Staff:
W. Harold Parham, D.H.A.*

APPENDIX I

Premium History (1963-1981)

The following chart shows the steady increase in the cost of professional liability insurance in Florida.

Year	High	Low	JUA (\$250,000/\$750 Limit Occurrence)	
1963(1)	\$ 235	\$ 99		
1971(1)	3,723	332		
1972(1)	3,425	383		
1973(2)	4,325(2)	381		
1974(2)	4,974	438	High	Low
1975(2)	9,252	902	\$29,590	\$2,947
1976(3)	8,243	814	29,590	2,947
1977(4)	10,988	846	29,590	2,947
1978(4)	14,021	848	35,774	3,563
1979(4)	13,000	865	26,902	2,679
1980(4)	12,806	764	26,902	2,679
1981(4)	14,612	763	26,902	2,679
7/1/81			38,990	2,570

(1) Employers (\$100,000/\$300,000 Occurrence)

(2) Argonaut Insurance Company (\$250,000/\$750,000 Occurrence)

(3) FMA PLI Trust (\$500,000 claims made)

(4) Florida Physicians' Insurance Reciprocal (\$500,000 claims made)

Patient's Compensation Fund

(Unlimited Liability over \$100,000
Assessable to its Membership)

1975—\$1,000/yr. 1st year*

\$ 500/yr. each year thereafter

*All physicians in all areas of State

7/1/81**Low-\$698/yr. High-\$4,323

**3 classes of physicians in 2 territories

APPENDIX II

Professional Liability Insurance Trust

Individual groups of physicians outside of the purview of the responsibility of the Florida Medical Association formed Professional Liability Insurance Trust which is still in effect today. A review of the annual reports of these Trusts filed with the Florida Insurance Department reveals the following:

SUBJECT: Trust Funds***

Name of Fund	as of	Aggregate Excess Coverage	Policy Limits	Numbe Insured	Premiums Written	Assets	Liabilities	Trustees Account	Profit (or Loss)
Physicians' Protective Trust Fund	12/31/80	no aggregate	100,000	2,407	10,581,286	21,900,024	21,571,092	328,932	(102,014)
Caduceus Self- Insurance Fund, Inc.	12/31/80	no aggregate	100,000	536	3,116,155	12,357,736	12,335,182	22,554	66,872
South Pinellas Medical Malpractice Risk Management Association	12/31/80	*	100,000	126	322,926	1,389,079	1,424,584	(35,505)	(22,494)
South Broward Hospi- tal District Physicians' Professional Liability Insurance Trust	12/31/80	2,000,000**	100,000	270	1,639,790	5,964,265	8,509,600	(2,545,335)	(48,150)
North Broward Hospi- tal Dist. Trust Fund (None available for 1980)	12/31/79	no aggregate	100,000	341	1,214,932	5,380,734	5,478,830	(98,096)	(36,792)

*Information in one portion of report says \$200,000 aggregate and responds "no" in another section.

**Reinsured with Physicians Reinsurance Limited

***Other physician trust funds exist in Florida, which are not reported here.

"The Process of Aging" Is Theme for 108th Annual FMA Meeting

The 108th Annual Meeting of the Florida Medical Association will be held at the Diplomat Hotel in Hollywood, Florida, May 5-9, 1982.

The FMA Board of Governors has approved "The Process of Aging" as the theme for the scientific program, and each FMA-recognized specialty group has been asked to consider making a contribution toward this subject in its scientific section, according to Calvin W. Martin, M.D., of Arcadia, Chairman of the Subcommittee on Annual Meeting Scientific Program.

Once again, scientific programs will be conducted Wednesday afternoon, May 5; Thursday afternoon, May 6; all day Friday, May 7; and Saturday, May 8.

Application will be made to the Florida Medical Foundation's Committee on Continuing Medical Education for co-sponsorship of the program and designation of 20 hours of AMA Category I Credit.

Dr. Martin said his Subcommittee has received these completed scientific programs so far:

THURSDAY AFTERNOON, MAY 6

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians, and Florida Thoracic Society)

Thursday, May 6 — 1:00 p.m. to 4:00 p.m.

Mark Snider, M.D., South Miami
Program Chairman

"Cardiopulmonary Function at Various Levels of Activity"

"Sleep Disordered Breathing" — James W. Wynne, M.D., University of Florida College of Medicine, Gainesville.

"Cardiac Exercise and Stress Testing" — James Margolis, M.D., Cardiac Catheterization Laboratory, South Miami Hospital, Miami.

"Pulmonary Exercise Physiology" — Norman L. Jones, M.D., McMaster University Health Science Center, Hamilton, Ontario.

SECTION ON NEONATAL-PERINATOLOGY

(Co-sponsored by Florida Society of Neonatal-Perinatologists)

Thursday, May 6 — 1:30 p.m. to 5:00 p.m.

Ronald N. Goldberg, M.D., Miami
Program Chairman

"Developmental Problems of Prematurity"

"Management of the Tiny Baby" — Keith F. Kanarek, M.D., Assistant Professor of Pediatrics, University of South Florida College of Medicine, Tampa.

"Intraventricular Hemorrhage in the Preterm Infant" — Emelee Setzer, M.D., Assistant Professor of Pediatrics, University of Miami School of Medicine, Miami.

"Retrolental Fibroplasia: 1982 Update" — John T. Flynn, M.D., Professor of Ophthalmology, University of Miami School of Medicine, Miami.

"Sudden Infant Death: Developmental Aspects and Management" — Tilo Gerhardt, M.D., Associate Professor of Pediatrics, University of Miami School of Medicine, Miami.

"Factors Influencing the Ultimate Developmental Outcome of the High-Risk Neonate" — Charles R. Bauer, M.D., Associate Professor of Pediatrics, University of Miami School of Medicine, Miami.

FRIDAY AFTERNOON, MAY 7

SECTION ON PSYCHIATRY (SECTION I)

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)

Friday, May 7 — 1:00 p.m. to 5:30 p.m.

Fred A. Peisner, M.D., Orlando
Program Chairman

"Psychiatric Development From Infancy to Death"
Introduction — Fred A. Peisner, M.D., Program Chairman, Orlando.

"Infant Psychiatry" — Martin Lazoritz, M.D., Clinical Assistant Professor of Psychiatry, University of Florida College of Medicine, Winter Park.

"Child Psychiatry" — Archie A. Silver, M.D., Associate Professor of Psychiatry and Chief of Child Psychiatry, University of South Florida College of Medicine, Tampa.

"Adolescent Development Disturbed by Psychiatric Illness" — Melvin S. Wise, M.D., Clinical Associate Professor of Child Psychiatry, University of Miami School of Medicine, Miami.

"Common Psychiatric Problems and Adaptations of Young Adults" — John E. Adams, M.D., Professor and Chairman, Department of Psychiatry, University of Florida College of Medicine, Gainesville.

Panel — Drs. Lazoritz, Silver, Wise and Adams.

SECTION ON ENDOCRINOLOGY AND ORTHOPEDIC SURGERY

(Co-sponsored by Florida Endocrine Society and Florida Orthopedic Society)

Friday, May 7 — 1:00 p.m. to 4:30 p.m.

James E. Vance, M.D., West Palm Beach

Program Chairman

"Aging and Osteoporosis: Cause and Effect?"

"Osteoporosis — Etiology and Natural History" —

C. Conrad Johnston Jr., M.D., Professor of Medicine and Chief, Division of Endocrinology, Indiana University Medical Center, Indianapolis, Indiana.

Clinical Case Presentations and Discussion — Peter Weissman, M.D., Clinical Associate Professor of Medicine, University of Miami School of Medicine, Miami.

"Osteoporosis — Surgical Aspects" — (Speaker to be announced).

"Medical Treatment" — C. Conrad Johnston Jr., M.D., Indianapolis, Indiana.

SATURDAY MORNING, MAY 8

SECTION ON PSYCHIATRY (SECTION II)

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)

Saturday, May 8 — 8:00 a.m. to 12:00 noon

Fred A. Peisner, M.D., Orlando

Program Chairman

Introduction — Fred A. Peisner, M.D., Program Chairman, Orlando.

"Being an Adult" — Philip B. Phillips, M.D., President, Southern Psychiatric Association, Pensacola.

"The Meal Ticket Syndrome: Masked Depression in the Middle Years" — James N. Sussex, M.D., Professor and Chairman, Department of Psychiatry, University of Miami School of Medicine, Miami.

"The Inner Life of the Older Person" — Eric A. Pfeiffer, M.D., Director, Suncoast Gerontology Center, University of South Florida College of Medicine, Tampa.

"Coping and Management of Terminal Illness and Death" — John M. Kulda, M.D., Assistant Professor of Psychiatry, Chief of Community Psychiatry and Director of Residency Training, University of Florida College of Medicine, Gainesville.

Wrap-up Panel — Drs. Phillips, Sussex, Pfeiffer and Kulda.

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy Society)

Saturday, May 8 — 8:30 a.m. to 12:30 p.m.

Thomas M. Brill, M.D., Gainesville

Program Chairman

Welcome — Richard F. Lockey, M.D., President, Florida Allergy Society, Tampa.

"Allergic Significance of Cypress and Australian Pine Pollens" — Gerald Bucholtz, M.D., Advance Sub-Specialty Resident, Allergy and Immunology, University of South Florida College of Medicine, Tampa.

"Relationship of Pediatric Respiratory Illness to Adult Airway Obstructive Disease" — Elliot F. Ellis, M.D., Professor and Chairman, Department of Pediatrics, State University of New York at Buffalo, New York.

"The Allergenic Significance of Melaleuca or Punk Tree" — John J. Stablein, M.D., Assistant Professor of Medicine, Division of Allergy and Immunology, University of South Florida College of Medicine, Tampa.

"Immunologic Aspects of Fixed Drug Eruptions" — Roger W. Fox, M.D., Assistant Professor of Medicine, Division of Allergy and Immunology, University of South Florida College of Medicine and James A. Haley, Veterans Administration Hospital, Tampa.

"Troleandomycin (TAO) in the Treatment of Severe, Intractable, Corticosteroid-Dependent Asthma" — Elliot F. Ellis, M.D., Buffalo, New York.

"Effects of Passive Smoking on Small Airway Function" — Heinz J. Wittig, M.D., Director of the Allergy Clinic, Ochsner Clinic and Hospital, and Clinical Professor of Pediatrics, Tulane University, New Orleans, Louisiana.



The Joint Commission on Accreditation of Hospitals . . . has added five hospitals to the list of institutions due for reaccreditation surveys during the last quarter of 1981.

Due for visitation between October 1 and December 31, 1981, are: Brandon Community Hospital, Brandon; Clearwater Community Hospital, Clearwater; South Florida Baptist Hospital, Plant City; and University Community Hospital and Women's Hospital, both of Tampa.

An original list of 17 hospitals slated for survey during the last quarter was published in the October issue of *The Journal*.

Dr. George Viscomi . . . has been elected President of the American Academy of Otolaryngic Allergy (formerly the American Society of Ophthalmologic and Otolaryngologic Allergy). Dr. Viscomi is a practicing Allergist and Ear, Nose and Throat Specialist in Clearwater, Florida.

Neurology residents . . . and medical students at the J. Hillis Miller Health Center, University of Florida, have a new resource facility this year — a library named in honor of **Dr. Melvin Greer**, Chairman of the Department of Neurology. Dr. Greer has been a faculty member of the College of Medicine for 20 years.

Robert L. Simons, M.D. . . . North Miami Beach, has been re-elected treasurer of the American Academy of Facial Plastic and Reconstructive Surgery. Dr. Simons is assistant professor of clinical otolaryngology, Department of Otolaryngology, University of Miami School of Medicine.



Dr. Simons



FMA AUXILIARY

Coping With Grief

In 1974, **Susan Eckstein**, a member of the Hillsborough County Medical Society Auxiliary, and her husband **Paul**, lost their daughter **Laura**. Born with severe cardiac defects, Laura died during surgery when she was eleven days old.

"It seems ironic", Susan recalls, "that my husband had been accepted into a cardiac surgery training program, and then our daughter was born with such severe problems. We were fortunate that we were able to communicate with each other, both during the crisis and after. We also had good friends who were very supportive. I, particularly, depended on their willingness to listen. The opportunity to talk helped me to recover much faster than I could have without that support."

Susan joined the Board of Directors of **Neo-Natal HOPES**, Helping Other Parents Experience Sorrow, in February of this year. She had been introduced to this grief-support group by a friend nineteen months before. After completing counselor training, she began working with women who had recently lost children.

HOPES was founded in 1979 by two grief-stricken mothers, Suzanne Addressi and Jo Moore, who felt an urgent need for a support group that could share and understand the grief of bereaved parents who have suffered either a miscarriage, stillbirth, or death of a newborn. Jo Moore is the group's director and the driving force behind it. Also on its board are Dr. Ken Solomon, a neonatologist, and Dr. Brenda Whittington, a psychologist. Dr. Whittington leads counselor training sessions on the grief process, normal and abnormal grief, how to listen, and how the death of a child affects a marriage.

A nonprofit organization operating only from donations, HOPES holds monthly meetings during which parents share their feelings and receive support from each other. Lay counselors, all of whom have experienced their own loss through neo-natal deaths, offer friendship and understanding. They work to help parents learn how to cope with shock, anger, confusion, guilt, depression, withdrawal, and physical complaints. A wide range of emotions is experienced by bereaved parents working through a mourning period.

Based in Tampa, HOPES receives referrals from physicians, nurses, crisis lines, mental health centers, families and friends. It distributes literature dealing with grief and infant death, and the needs and sensitivities of people who are suffering because of it. It also provides speakers to interested groups. Physicians who have referred their own patients to HOPES consider it a valuable resource for the community.

Susan and Paul Eckstein, having found HOPES, were finally able to come to terms with their loss. They have recently jointly counseled a couple whose baby was born with cardiac defects.

Grief, and grief-related problems, is an area of need that the medical auxiliary has begun to earnestly address.

Lee County Medical Society Auxiliary has an ongoing project on "Coping With Grief" utilizing a council of professionals who assist area residents with such problems.

From Escambia to Dade, auxiliaries are holding seminars on subjects that include "Coping With Aging," "Coping with Loneliness," and "Coming to Terms With Death and Terminal Illnesses." Some counties have been running "Worry Clinics" on such subjects.

The new decade that has led us soaring into new and uncharted pathways among the stars has also thrust economic and emotional havoc upon us, creating different dimensions to our twentieth century stresses. Proving itself equal to this new set of challenges, the medical auxiliary has spawned in its midst a special breed of concerned community volunteers who, singly or as a group, are responding to them.

*Mrs. Rod M. Martija
Communications Chairman, FMAA
Longwood, Florida*

The mailing address for HOPES is P.O. Box 1143, Lutz, Florida 33549

WORTH REPEATING

Best Medical Judgment

The notoriety given recently to court-ordered treatment for hopelessly joined Siamese twins, a newborn with a myelomeningocele, and the frantic rushing about the country in search of a neonatal intensive care bed made me ask myself, "Whatever happened to good old-fashioned medical judgment"? I don't know the merits of those particular cases, but they are symbolic.

At one time decision making was a very personal matter between physician and his patient and family. The doctor rendered his advice based on his "best medical judgment." The patient considered it in concert with his family and made a decision. In most cases the clergyman was also involved for counseling and emotional support. Somehow this tradition seems to have been lost. True, much significance is still given, on the witness stand, to questions that begin, "Now in your best medical judgment—?", but in actual practice that judgment seems to be seldom used. As in politics, the practice of medicine today seems to be based on the art of the possible. The role of judgment in making decisions has been eliminated when one equates something being possible with that same something being desirable or good, and that appears to be the attitude that physicians are taking. As a result, the public has been given unreal expectations. They have been influenced by having possibilities presented to them untempered by good medical judgment. I attribute responsibility for this sad state to the secularization and commercialization of society and deplore the same occurrence in our profession. Where is medical judgment when patients are submitted to tests, the results of which, normal or abnormal, will not influence their treatment? Can a supertrained technician with little personal relationship to his or her patient and family really exercise good medical judgment when the ICU, the Cath lab, or the operating room provide, at the same time, his or her playground and livelihood? Is best medical judgment better developed from a battery of test results or from an intimate knowledge of the patient, obtained by means of a careful and detailed history and physical examination?

I think we all must agree that when it comes to medical decision making the doctor is no longer the

central figure. I must ask once again, "Have we abdicated our responsibility or has that responsibility been usurped by others"? My own opinion is that it was initially usurped but then gradually we abdicated. The medical profession seems to be confused by a culture that has developed around the study of situational ethics. This culture has developed in response to the remarkable technological accomplishments which have created the art of the possible. Attempts are being made to find solutions to thorny medical situations by people who have no basic medical understanding. These ethicists have become adept at counter balancing a situation and its solution with a totally reversed solution to the same situation and then through contortions of reasoning base the solutions on certain "rights" which they either assume or create. As a result we doctors have been immobilized by indecision. We now find crises in what were once rather straightforward medical decisions.

Can we restore some significance and value to "our best medical judgment"? I think we must and I think we can. First we must insist that our educational system insure that its products are capable of developing "good medical judgment." Then, as a profession we must disavow the commercialization and secularization by adherence to a code of behavioral ethics which I hope has not been diluted to a point of ineffectiveness. If we do this I think that our credibility will be restored sufficiently to permit a return to a simpler and more personal manner of problem solving. The decisions may not always be right but they will be a lot more sensible than many of those now being made by committees or by the courts. I would prefer to stake my life and welfare on decisions reached jointly with a good doctor whose base is education and experience and family which is influenced by love and religious conviction. With these elements present, outside intervention would seldom be needed.

James K. Conn, M.D.
Tallahassee

Reprinted from: The Capital Medical Society Newsletter, August 1981

Competition—The New Threat

With the dramatic swing to the right that has taken place in Washington, there has been developing an equally dramatic change in approach to what has been seen as the "Problems with American Medicine" and the language used to discuss those problems. For the time being, at least, there is no more talk of "Health Care for All Americans" or other such schemes for cradle to grave National Health Insurance. The catch word this year is "competition." The banner of competition has been grabbed up by so many different elements of the government that the AMA has begun to disassociate itself with the concept and push instead for "consumer choice." To the uninitiated there might seem to be little difference in the two labels, but it appears that the medical world is destined to redefine the terms significantly in the next few years.

It is believed by many — and is certainly true to a certain extent — that one factor in the rising costs of health care in recent years has been the failure of third party payors to promote competition in costs while competition in available services has been rewarded. Medicare, Medicaid, and the Blues have based their payments on hospital costs and on physician charges without any real pressure to restrain either. Hospitals that cost the most and physicians who charge the most are paid the most. In some parts of the country, there are hospital and nursing home beds that are chronically empty, but since these beds add to the institutions' costs, they have also added to their third party payments. There are many forces in the administration and Congress that mean to put a stop to this situation one way or another. One current plan being considered in the Congress would allow states to limit the choice of Medicaid recipients to an approved list of providers, thus giving the state more leverage to negotiate what costs they are willing to pay.

Such measures within the legitimate medical community are not entirely without merit and certainly deserve close attention and a willingness to seek an appropriate solution to the problems involved. Much more threatening to the continuation of good medical care in this country, however, are the further ramifications of the "pro-competition" movement. Many of our political leaders see the problem as not just a need for more competition between medicine and other forms of

"health care". They would promote utilization by the health consumer of the cheapest possible form of health provider, whether that be a nurse practitioner, a chiropractor, a naturopath, or whatever. If a medical doctor wanted a piece of the fiscal action, he would have to cut his prices to compete. Such an attitude has already begun to have a significant ripple effect across the country. Nurse practitioners and physician's assistants are seeking ever-increasing autonomy. Naturopaths and Homeopaths are making a comeback, while "Holistic Medicine" is developing a conglomerate of faith healers, vitamin pushers, auriculopuncturists, and whatnot. The franchise movement that worked so well for McDonalds and Col. Sanders has already been adopted by the abortionists and diet doctors and is beginning to show signs of catching hold with Health Maintenance Organizations. In such an atmosphere it is probably going to be surprisingly difficult for organized medicine to convince many of our leaders of the importance of maintaining some standard of the value of the health care delivered as opposed to its costs. We may very well find ourselves fighting for more regulation after all the years we have been seeking less. There has already been a movement in California to deregulate the practice of medicine, and we saw enough of deregulation of Psychologists in Florida to know where that would lead.

The AMA is acutely aware of these threats and has already begun to fight to maintain the nation's standards of health care while attempting to control runaway costs by increasing the importance of "consumer choice." They will need our support in this fight both as a group through society and PAC membership and as individuals in our contacts with our elected representatives. To support them we will have to stay abreast of the everchanging situations in government and be aware that "competition" and "decreased regulation" may not always be the fine old conservative virtues we have supported in the past.

Henry L. Harrell, Jr., M.D.
Ocala

Reprinted from: Bulletin of the Marion County Medical Society, October 1981.

Professional Courtesy

No, this isn't about treating your colleagues' families gratis. It's about treating your colleagues—courteously.

There is an increasing tendency for physicians to communicate with one another in an offhand, rather cold manner, as if the act of transmitting information is all that matters, and the form it takes is unimportant. The passing of knowledge is more effective and more pleasant when done with a bit of a personal touch, and with respect for the other individual's convenience and self respect. Here are some common means of communication we each use regularly and frequently abuse.

Nearly every physician consults (or is consulted) sooner or later by another—either in a hospital, through an office visit by the patient, or on the telephone. How do you contact your consultant? Do you write an order and let the nurse call him (a procedure that is against the bylaws in at least one of our hospitals) or do you call him yourself and let him know what sort of help you need? If he appears and modifies the treatment without discussion, do you get upset? You have no right to, if you didn't give him the courtesy of telling him you wanted guidance, not a takeover.

If you are the consultant, do you tell the patient you are going to contact the attending physician, and do so, or do you just forge ahead, leaving the already distressed patient confused about who's in charge? There is a difference, after all, between a "consultation" and a "referral." By knowing ahead of time what you expect (or what is expected of you) everyone benefits—especially the patient.

Another form of discourtesy is use of the telephone. A significant percentage of us tell our secretaries, "Call Dr. X on the phone." Dr. X's office staff gets him, then he sits and waits for the caller to finish up something and come on the line. It is hard for the doctor being called not to infer that the caller feels that his time is more valuable, his convenience more important. The result of this rudeness is often a feeling of resentment, which can be avoided by the simple expedient of dialing one's own calls. Besides, most receptionists will really hustle to get their boss on the phone when they hear "This is Dr. Y," and you'll probably end up saving time as well.

Recently, I overheard a conversation in a doctor's lounge. A family practitioner was describing a form letter he'd received from a medical subspecialist, and complaining that it was "less than useless." It was a smaller-than-usual sheet (not 8½ x 11) and difficult to file. It had a series of blanks and boxes that the consultant filled out or checked. The words were illegible and the patient's last name was misspelled.

No doubt the specialist involved felt very efficient, and still wonders why he doesn't see that physician's patients any more. The simple expedient of a phone call (self-dialed, of course) followed by a detailed report, would have saved a referral source.

If one reflects about it a moment, these problems represent the non-application of the Golden Rule, except that there's a third party involved—the patient. If we each think before acting about how we make contact with our colleagues, as well as why, life would be more efficient and pleasant, and have less potential for possible dangerous confusion.

*Fred H. Olin, M.D.
Bexar County, Texas*

Reprinted from: American Medical News, September 4, 1981.



**Christmas Seals®
fight lung disease**

Space contributed by the publisher as a public service

Medical Decorators

NEW OR EXISTING SPACE
PROFESSIONALS WORKING
AROUND YOUR SCHEDULE

(305) 772-0090
By Appointment

CARY MARTIN
5055 N.E. 13 Ave.
Fort Lauderdale, Fla. 33334

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal*.

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Abstract. All scientific manuscripts should include a 150 word, maximum length, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given:

names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation: "References are available from the author(s) upon request".

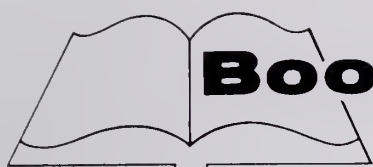
All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double-spaced on a separate sheet of paper. The following information should be typed on an adhesive strip and affixed to the back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication".

When received, the senior author will be sent an acknowledgement of receipt and a copyright agreement which must be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Atlas of Medicinal Plants of Middle America, Bahamas to Yucatan, by Julia F. Morton. 1420 pages. Price \$147.50. Charles C. Thomas Publisher, Springfield, Illinois, 1981.

Authored by Florida's own Julia Morton, this unique and authoritative reference book is probably destined to become the primary reference book covering medicinal plants in the area of the world indicated. The text encompasses more than 1,000 medicinal plants used by the peoples of the northern part of South America, the West Indies, the Bahamas, Central America as far north as Yucatan, and large sections of the coast of the Southeastern United States.

The major section of the book presents the plants grouped together by families, which number more than 150. Genera are presented alphabetically within each family, species are arranged alphabetically within each genus. For each species, the author provides a detailed description and information on the following: geographical origin and distribution, scientific names, vernacular names, including those in English, Spanish, Portuguese, Dutch, French, Papiamentu, and American Indian; chemical constituents, medicinal uses of the whole plant, or parts thereof; properties and effects, including toxicity; and food uses, and other economic uses.

This portion of the book, entirely in graphic and outline format, takes up 984 pages of the text. Following this section there are 541 illustrations (all B & W) of those plants regarded as the primary considerations.

The next major section of the book is a classified list of medicinal plants, according to principal uses. This section lists, under major medical uses, the genus and species of the plants having the indicated medicinal value. This list indicates medical uses ranging from abortifacients, anemia, angina, aphrodisiacs, cancer, dysentery, epilepsy, menstrual difficulty, vermifuges, to yaws. Dozens of other medicinal uses are included in between.

There is an extensive bibliography.

There are two major indices, in addition to those previously noted. One lists the scientific names of the plants, indexed according to page numbers. Another major index is according to the vernacular name and page number where the plant is found.

Although the price of this text (\$147.50) will probably

preclude its widespread purchase, students and professionals interested in folk medicine, medical and general botany, phytochemistry and related fields, as well as anthropologists, pathologists, toxicologists, sociologists and epidemiologists, will discover a wealth of information.

In all probability, this text will become a major reference in the area of medicinal botany and biology. It certainly should be available in every major medical and scientific library.

Julia Morton is Director of the Morton Collectanea, University of Miami, Coral Gables, Florida. The FMA has received the benefit of her help in the past, especially in the award winning issue of *The Journal of the Florida Medical Association*, March 1978.

L. E. McHenry, M.D.

Dr. McHenry is a practicing pathologist in Melbourne, Florida, and was guest editor of the *Journal's* special issue: "Adverse Reactions to Plants in Florida," March 1978.

The Physicians' and Pharmacists' Guide to Your Medicines, by the United States Pharmacopeial Convention. 521 Pages. Price \$9.95. Ballantine Books, New York, 1981. Paperback.

Drugs are arranged alphabetically by generic name. Each section is written in clear language for the layman.

A paragraph or two is included about the general use of the drug, precautions and proper use as well as side effects.

A major weakness, from this reviewer's point of view, is that there is no notation about the approximate cost of each drug.

The index includes brand names so that the patient may look up his drug even if he doesn't know the generic name.

This book may be useful to certain patients who feel they need specific, fairly complete information of the medicines they take. Physicians may find the format useful in making up their own patient information sheets for commonly used medicines.

F.N.V.

THE APPROPRIATE GIFT FOR
AN INTERN OR RESIDENT

Give a year's subscription to the

**Journal of the Florida
Medical Association**

CUT OUT AND MAIL TO:

FLORIDA MEDICAL ASSOCIATION
Post Office Box 2411
Jacksonville, Florida 32203

Please send my gift subscription to:

Dr. _____
Mr. _____
Ms. _____ Status: _____

Street _____

City & State _____

Send the bill for \$15.00 (add .60 sales tax if you live in Florida)

Dr. _____

Street _____

City & State _____

The Physicians' Drug Manual, Prescription and Nonprescription Drugs, edited by Rubin Bressler, M.D., Morton D. Bogdonoff, M.D. and Genell J. Subak-Sharpe, M.S. 1,213 Pages. Price \$17.95. Biomedical Information Corporation, Doubleday and Company, Inc., Garden City, New York, 1981.

This encyclopedic volume is intended to give drug information both to the health professional and to the sophisticated non-medical reader. To determine how this might serve the needs of the non-medical reader, I conducted a small experiment. The book was brought to a weekend outing at which several couples, all college graduates, were present. They were invited to use the book to look up medicines they had heard about or that they, or relatives, might have been taking. Although a glossary of common medical terms was included, it was quickly discovered that many terms used in the book were not included in the glossary. Most lost interest quickly upon having to look up several medical terms.

Trial use of the book was made in a medical office to see whether the medical staff would use it and how much in comparison with the standard *Physicians' Desk Reference (PDR)*. The PDR was chosen for use by the office staff more frequently; presumably, this related to their being more familiar with the PDR and the fact that more detailed information was contained therein.

This book, from my point of view, will find its usefulness as an encyclopedic reference for libraries and for the highly motivated non-medical reader.

F.N.V.

Books Received

Receipt of the following books is acknowledged.

Clinical Cardiology, 3rd edition, Maurice Sokolow and Malcolm B. McIlroy. 763 Pages. Price \$21.50. Illustrated. Lange Medical Publications, Los Altos, California, 1981.

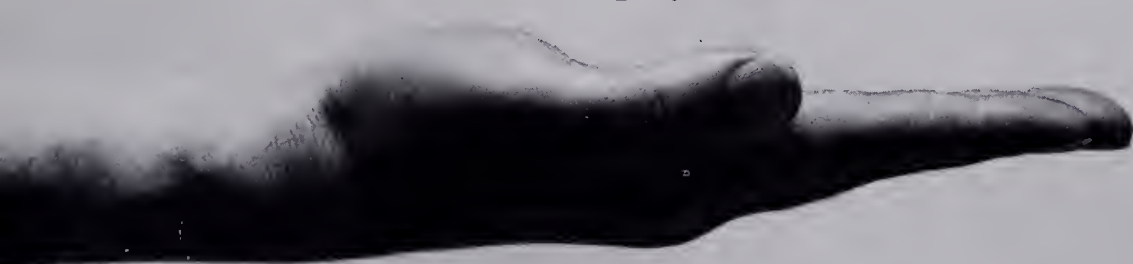
Legal Rights of Asbestos Exposure Victims, Roman M. Silberfeld and Richard L. Hecht, authors and publishers. 14 Pages. Free. Los Angeles, California, 1980.

Lifelong Sexual Vigor: How to Avoid and Overcome Impotence, Marvin B. Brooks, M.D., FACS. 249 Pages. Price \$12.95. Doubleday and Company, Inc., New York, New York, 1981.

There's more to **ZYLOPRIM[®]** than (allopurinol).



- From Burroughs Wellcome Co. – the discoverer and developer of allopurinol
- Patient starter/conversion kits available for easy titration of initial dosage
- Patient compliance pamphlets available
- Continuing medical education materials available for physicians



Prescribe for your patients as you would for yourself.

*Write "D.A.W.," "No Sub," or "Medically Necessary,"
as your state requires, to make sure
your patient receives the original allopurinol.*



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

**When painful spasm
is the presenting
symptom...**

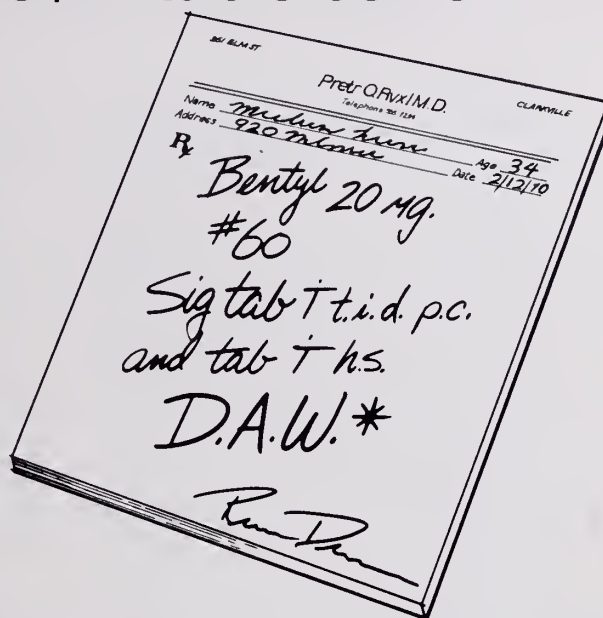


...in the functional bowel/irritable bowel syndrome*

be sure to specify

Bentyl[®]
(dicyclomine hydrochloride USP)

10 mg capsules, 20 mg tablets,
10 mg/5 ml syrup, 10 mg/ml injection



**D.A.W.-Dispense as written*

because:

- ⊕ The Bentyl molecule is a product of original Merrell research.
- ⊕ At Merrell Dow, Bentyl must go through 140 checkpoints/tests from its synthesis through the packaging of the final product.
- ⊕ Bentyl bioavailability of tablets, capsules, syrup and injectable is evidence of its prompt absorption.
- ⊕ Bentyl helps control abnormal gastrointestinal motor activity with minimal anticholinergic side effects. (See Warnings, Contraindications, Precautions, and Adverse Reactions on next page.)
- ⊕ The bioequivalence of the oral dosage forms permits a choice of tablet, capsules, or syrup that satisfies patient's dosage preferences.
- ⊕ Significant pharmacologic effect in the distal colon compared to placebo,¹ shows how Bentyl controls abnormal motor activity in the irritable colon patient.*

*This drug has been classified "probably" effective for this indication.

Merrell Dow

Reference:

1. Chowdhury AR and Lorber SH: Personal communication, 1980.

(See Product Information on the next page before prescribing Bentyl.)

Although the dose of Bentyl used to show pharmacologic effect was 50 mg, which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg (2 ml) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg dose. Presumably, the same pharmacologic effect would follow. These observations do not constitute evidence of efficacy.

Bentyl®**(dicyclomine hydrochloride USP)**

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FOA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSEAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of July, 1980

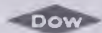
Injectable dosage forms manufactured by

CONNAUGHT LABORATORIES, INC.

Swiftwater, Pennsylvania 18370 or

TAYLOR PHARMACAL COMPANY

Oecatur, Illinois 62525 for

Merrell

MERRELL DOW PHARMACEUTICALS INC.

Subsidiary of The Dow Chemical Company

Cincinnati, OH 45215 U.S.A.

1-7052 (7368C)

MNQ-712

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

TUTORIAL COURSES OF INSTRUCTION IN CORONARY CARE

Director: Louis Lemberg, M.D.

Co-Directors: Kyriacos Pefkaros, M.D.
Robert J. Myerburg, M.D.

SCHEDULE OF COURSES

1981

August 3-8
September 14-19
October 26-31
December 7-12

1982

January 18-23
February 15-20
March 8-13
March 29-April 3
June 14-19

(For more information please call (305) 325-6411 or complete coupon and mail to: M. Enriquez, Division of Cardiology (D-39), University of Miami School of Medicine, Post Office Box 016960, Miami, Florida 33101).

Please send me more information regarding
Tutorial Courses of Instruction in Coronary Care

Name _____

Phone () _____

Address _____

_____ Zip _____

MEETINGS

Accepted by the FMA Committee on Medical Education for Mandatory Credit

DECEMBER

Primera Conferencia Latinoamericana en Oncologia (in Spanish), Dec. 1-5, Bal Harbour. For information: Peter Mansell, M.D., Dept. of Oncology/Comprehensive Cancer Center, P.O. Box 016960, Miami 33101.

The 1981 Neuro-Ophthalmology Course, Dec. 3-5, Miami. For information: Gaby Kressly, Dept. of Ophthalmology/Bascom Palmer Eye Institute, P.O. Box 016960, Miami 33101.

Ultrasound as Used in Modern OB-GYN, Dec. 6-10, Miami. For information: Dr. William Little, Dept. of OB-GYN, P.O. Box 016960, Miami 33101.

American Cancer Society — National Conference Gastrointestinal Cancer, 1981, Dec. 8-10, Fontainebleau Hilton Hotel, Miami Beach. For information: Nicholas G. Bottiglieri, M.D., American Cancer Society, National Conference, Gastrointestinal Cancer, 1981, 777 Third Avenue, New York, New York 10017.

Third Annual Mississippi Perinatal Postgraduate Course, Dec. 10-11, Jackson, Mississippi. For information: John C. Morrison, M.D. and Philip G. Rhodes, M.D. University of Mississippi Medical Center, Jackson, Mississippi 31296.

Advanced Epidemiology, Dec. 11-12, Miami. For information: Janet Konefal, Dept. of Epidemiology and Public Health, P.O. Box 016960, Miami 33101.

2nd Annual Interamerican Medical Symposium (in English/Spanish), Dec. 13-17, Bal Harbour. For information: Jose Bocles, M.D., Department of Medicine, P.O. Box 016960, Miami 33101.

Conferences in General Medicine and Family Medicine, Dec. 14, International Hospital, Miami. For information: Alfredo Crucet, M.D. and Heather Childs, Dept. of Family Medicine, P.O. Box 016960, Miami 33101.

The Fourth Winter Seminar-Medicine for Tomorrow, Dec. 20-Jan 3, Aspen, Colorado. For information: DCMA, 1501 N.W. North River Drive, Miami 33125.

JANUARY

Classification, Clinical Court and Immunology of Malignant Lymphomas, Jan. 5, Fort Lauderdale. For information: John Fichtelman, M.D., P.O. Box 23460, Fort Lauderdale 33307.

Arthroscopic Update Emphasizing Problem-Solving in Therapeutic Arthroscopy of the Knee, Jan. 10-14, Sandpiper Bay, Port St. Lucie. For information: Ronald S. Grober, M.D., 2000 Nebraska Avenue, Ft. Pierce 33450.

5th Annual Oral Pathology Review, Jan. 11-15, Miami. For information: Gloria Allington, Dept. of CME, P.O. Box 016960, Miami 33101.

Family Practice Grand Rounds, Jan. 13, 27, Jacksonville. For information: Mary B. Kellogg, M.D., 655 W. 8th St., Jacksonville 32209.

Update 1982—Management of Asthma and COPD, Jan. 14-16, St. Petersburg. For information: Dale E. Braddy, 911 Busse Highway, Park Ridge, Ill. 60068.

27th Annual Cardiovascular Seminar, Jan. 15-16, Holiday Inn Surfside, Clearwater Beach. For information: Mr. E. Jerry Eatman, American Heart Association, P.O. Box 7188, St. Petersburg 33734.

Continuing Education in Pediatrics—1982, Jan. 17-21, Hollywood, Fla. For information: D.H. Altman, M.D., 6125 S.W. 31st St., Miami 33155.

Rx for a Healthy Heart, Jan. 18-21, Clearwater Beach. For information: Henry J.L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

Radiology for the Non-Radiologist, Jan. 18-22, Innisbrook, Fla. For information: Edward A. Eikman, M.D., 3100 East Fletcher Ave., Tampa 33612.

Clinical Immunology: Update for the Practitioner, Jan. 20-23, Lake Buena Vista, Fla. For information: JHM Health Center, Box J-233, Gainesville 32610.

Fourth Annual Walt Disney World Pulmonary Wintercourse, Jan. 21-24, Lake Buena Vista, Fla. For information: Asher Marks, M.D., 5526 Arlington Rd., Jacksonville 32239.

Round Table Day, Jan. 22, Hollywood, Fla. For information: Donald F. Altman, M.D., 6125 S.W. 31st St., Miami 33155.

Principles of Practice Management, Jan. 23-30, Vail, Colorado. For information: Sonja Auxier, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101.

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREbro-NICIN® capsule
contains:

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons ex-
perience a flushing and tingling
sensation after taking a higher
potency nicotinic acid. As a sec-
ondary reaction some will com-
plain of nausea, sweating and ab-

dominal cramps. The reaction is
usually transient.

INDICATIONS: As a cerebral
stimulant and vasodilator.

**RECOMMENDED GERIATRIC
DOSAGE:** One capsule three
times daily adjusted to the indi-
vidual patient.

WARNING: Overdosage may
cause muscle tremor and convul-
sions.

CONTRAINDICATIONS: Epilepsy
or low convulsive threshold.

CAUTION: Federal law prohibits
dispensing without prescription.
Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Symposium on Intensive Care, Jan. 23-31, Vail, Colorado. For
information: Sonja Auxier, Dept. of Anesthesiology, P.O. Box 016960,
Miami 33101.

7th Annual Review and Recent Practical Advances in Pathology,
Jan. 25-29, Bal Harbour. For information: Dr. Sharon Thomsen, Dept.
of Pathology, P.O. Box 016960, Miami 33101.

The Clinical Approach to Exercise Testing, Jan. 28-30, Orlando.
For information: Ms. Betty Pac, P.O. Box 4835, Tampa 33677.

8th Annual Vail Conference in Anesthesiology, Jan. 30-Feb. 5,
Vail, Colorado. For information: Sonja Auxier, Dept. of Anesthesiol-
ogy, P.O. Box 016960, Miami 33101.

**9th Annual Symposium in Pediatric Nephrology: Current
Concepts in Diagnosis and Management**, Jan. 31-Feb. 4, Bal
Harbour, Fla. For information: Jose Strauss, M.D., Div. of Pediatric
Nephrology, University of Miami, Miami 33101.

FEBRUARY

**Florida Midwinter Seminar, Ophthalmology and Otolaryngol-
ogy**, Feb. 1-6, Fort Lauderdale: For information: Gaby Kressly, 405
N.E. 144 St., Miami 33161.

Second Symposium on Burn Care, Feb. 5-6, Gainesville. For
information: JHM Health Center, Box J-233, Gainesville 32610.

Family Practice Grand Rounds, Feb. 10, 24, Jacksonville. For
information: Mary P. Kellogg, M.D., 655 W. 8th St., Jacksonville 32209.

The Pulmonary Cripple, Feb. 20-21, Melbourne, Fla. For informa-
tion: George H. Mix, M.D. and J.L. Weare, M.D., 1304 S. Oak St.,
Melbourne 32901.

Third Annual Family Practice Update, Feb. 15-20, Daytona Beach.
For information: Richard W. Dodd, M.D., Halifax Hospital, Daytona
Beach 32015.

**The Professional and Chemical Dependency—Challenge for the
80's**, Feb. 18-21, West Palm Beach. For information: Ronald J.
Catanzaro, M.D., Palm Beach Institute Foundation, West Palm Beach
33405.

Ninth Annual Selected Topics in Urology, Feb. 25-27, Gainesville.
For information: JHM Health Center, Box J-233, Gainesville 32610.

Midwinter Seminar in Obstetrics and Gynecology, Feb. 25-27, St.
Petersburg. For information: James M. Ingram, M.D., U. of South
Florida College of Medicine, Tampa 33612.

Ninth Annual Pediatric Dermatology Seminar, Feb. 25-28, Miami.
For information: Guinter Kahn, M.D., 16800 N.W. 2nd Ave., Miami
33169.

Traditional and Modern Chinese Acupuncture, Feb. 27-28, Lake Buena Vista, Fla. For information: Joseph Bubenias, 50 Maple Place, Manhasset, N.Y. 11030.

Spinal Cord Injury, Feb. 28-Mar. 4, Walt Disney World, Orlando. For information: William Brown, M.D., P.O. Box 016960, Miami 33101.

MARCH

Basic Neurology for Psychiatrists and Generalists: A Comprehensive Review Course, Mar. 1-5, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Current Clinical Concepts in Otolaryngology 1982, Mar. 3-4, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Pan American Symposium on Cancer of the Head and Neck, Mar. 5-6, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Internal Medicine 1982, Mar. 7-12, Miami Beach. For information: J.S. Bocles, M.D., P.O. Box 016960, Miami 33101.

17th Annual Postgraduate Course in Internal Medicine, Mar. 7-12, Bal Harbour, Fla. For information: J.S. Bocles, M.D., P.O. Box 016960, Miami 33101.

14th Annual Teaching Conference in Clinical Cardiology, Mar. 10-13, Bal Harbour, Fla. For information: Michael Gordon, M.D., P.O. Box 016960, Miami 33101.

Family Practice Grand Rounds, Mar. 10, 24, Jacksonville. For information: Mary P. Kellogg, M.D., 655 W. 8th St., Jacksonville 32209.

Problems in Rheumatology, Mar. 11-14, St. Petersburg. For information: Bernard F. Germain, M.D., Box 19, University of South Florida College of Medicine, Tampa 33612.

Symposium on Glaucoma: Patient Evaluation, Surgical and Laser Therapy, Mar. 12, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

Intensive Care for Neurological Disease and Trauma, Mar. 14-18, Kissimmee, Fla. For information: Gloria Allington, P.O. Box 016960, Miami 33101.

13th Annual Topics in Internal Medicine, Mar. 18-20, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

St. Moritz 1982—Advances in Diagnostic Imaging, Mar. 21-28, Moritz, Switzerland. For information: Edward A. Eikman, M.D., 3100 East Fletcher Ave., Tampa 33612.

Orthopaedics for Family and Emergency Physicians, Mar. 24-27, Lake Buena Vista, Fla. For information: Allan W. March, M.D., JHMHC, Box J-222, Gainesville 32610.

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE
SEVENTEENTH ANNUAL POSTGRADUATE COURSE
“Internal Medicine 1982”

February 21-26, 1982

SHERATON BAL HARBOUR HOTEL MIAMI BEACH, FLORIDA

THE OBJECT OF THIS COURSE, THE SEVENTEENTH IN ITS SERIES, IS TO PROVIDE AN ANNUAL UPDATING OF THE MOST USEFUL RECENT ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF INTERNAL MEDICAL DISORDERS AS THEY ARE ENCOUNTERED BY PRIMARY CARE PHYSICIANS AND PRACTICING SPECIALISTS.

GUEST FACULTY

Sidney Cohen, M.D.
Professor of Medicine
University of Pennsylvania
School of Medicine
Philadelphia, PA

Robert A. Good, M.D.
Professor of Medicine and Pediatrics
Cornell University
Medical College
New York, NY

Seymour Reichlin, M.D.
Professor of Medicine
Tufts University
School of Medicine
Boston, MA

Martin Goldberg, M.D.
Taylor Professor of Medicine and Chairman,
Department of Internal Medicine
University of Cincinnati College of Medicine
Cincinnati, OH

Sol Sherry, M.D.
Professor of Medicine
Chairman, Department of Medicine
Temple University School of Medicine
Philadelphia, PA

HIGHLIGHTS

**VIDEOTAPE REVIEW OF
TOPICS
FOR BOARD REVIEW
IN INTERNAL MEDICINE**

Selected topics in Internal Medicine updated by the University of Miami faculty and primarily designed for physicians preparing for Board certification in Internal Medicine will be shown on a large TV screen.

FIVE MAJOR SYMPOSIUMS

Five major symposiums will present the newest developments in selected areas of internal medicine.

**MEET THE FACULTY SESSIONS
“CRITICAL CARE IN INTERNAL
MEDICINE”**

Simultaneous group meetings will present topics of **CRITICAL CARE IN INTERNAL MEDICINE**. Special emphasis will be given to the most recent advances in the management of the critically ill patient.

**PICTORIAL QUIZ • AUDIOVISUAL AIDS • SCIENTIFIC EXHIBITS
HOTEL ATTRACTIONS • SPOUSES ACTIVITIES**

38 Lecture Hours and 20 Self-Instruction Credit Hours, Category I, A.M.A.

REGISTRATION:

\$400/Physician

\$250/Physician in Training (letter from Chief of Service must accompany registration)

FOR REGISTRATION AND INFORMATION WRITE TO:

Jose S. Bocles, M.D.
Department of Medicine R760
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101
Phone: (305) 547-6063



works well in your office...

NEOSPORIN® Ointment (polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.

- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.

- It contains three antibiotics that are rarely used systemically.

- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Just tell us where you want to live.

Hospital Corporation of America assists hundreds of physicians in locating solid practice opportunities each year. With HCA, you can choose a community that fits your lifestyle and know that the local hospital's staff and facilities will reflect your own high professional standards.

HCA owns or manages over 150 hospitals from San Francisco to Virginia... from Boston to Miami. Each hospital is well equipped, and professionally accredited and staffed. Practice opportunities are available in solo, groups, associations and

partnerships.

Contact HCA today. Let our free, no obligation Professional Relations Program match your needs with an HCA practice opportunity. Just send your curriculum vitae, with information on your personal, professional, and geographic interests to: **Charles M. Wooden, Director, Professional Relations, Hospital Corporation of America, One Park Plaza, Nashville, TN 37203. Telephone toll free 1-800-251-2561 or call collect (615) 327-9551.**

HCA Hospital Corporation of America

When
impotence
is due to androgenic deficiency.

Android® 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg mg mg

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of male climacteric/eunuchoidism, eunuchism/post-pubertal cryptorchidism.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcaemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcaemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., J. B. Sipehoglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric, Drug Therapy, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250, Rx only.

Write for new double-blind study reports and samples.

CROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



DEVELOP A SEVENTY-FIVE MINUTE HOUR!



IN THE MEDICAL PROFESSION, TIME IS ONE OF YOUR MOST VALUABLE ASSETS!

LIGHTCOM medical communications and management systems will maximize the efficiency and improve the daily operation of your practice or health care facility. The light and digital systems are custom designed to meet your special needs and requirements. You are able to see more patients daily in a quieter and more controlled environment. You can communicate with and direct your staff instantly, discreetly with a single touch without knowing their location. All of this equals increased productivity through the most efficient use of personnel and examination rooms... thereby producing a more profitable practice or health care facility.

JOIN THE QUIET REVOLUTION!

LIGHTCOM manufacturers, markets and installs America's leading medical communication and management systems nationwide. Our systems are micro-processor based with patient examination sequence **MEMORY** capabilities.



Corporate Offices
5990 Unity Drive
Atlanta (Norcross), Georgia
30071-9990

LIGHTCOM

Phone:
(404) 447-5926

5990 Unity Drive
Atlanta (Norcross), Georgia 30071-9990

For more information, mail coupon.

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Specialty _____

**LAST CHANCE!
LAST CHANCE!
LAST CHANCE!**

FOR FLORIDA'S FINEST CITRUS AND SEAFOOD THE HEALTHFUL GIFT FOR FAMILY AND FRIENDS

Time is running short for your Christmas ordering of the finest in Florida's gourmet citrus and seafoods.

GET YOUR ORDER IN TODAY for your family and friends' favorite Christmas gift — HEALTHFUL citrus and seafood. DON'T LET THEM DOWN THIS YEAR.

Order Pak #30 1/2 Bushel (\$17.95) or #55 1 Bushel (\$26.95) and please specify ALL ORANGES, ALL GRAPEFRUIT OR OUR SPECIAL MIX OF 1/2 EACH FRUIT. For complete selection, write or call your local FMF chairman or Auxiliary president.

Ask about our 6 Month Fruit Plan or our 3 Month Fruit Plan, too. Brochures may be obtained from your local chairman.

Or contact:

Send orders to:

FLORIDA MEDICAL ASSOCIATION AUXILIARY
Mrs. David Whittaker
1140 S. E. Fort King
Ocala, Florida 32671

Benefits go to the FLORIDA MEDICAL FOUNDATION. Make checks Payable to: "FMA-AUXILIARY-FMF".

DEADLINE FOR HOLIDAYS November 30, 1981

Name: _____

Address: _____

Pak #30 (1/2 Bushel) _____ Pak #55 (1 Bushel) _____

All Oranges _____ All Grapefruit _____ Or Mix _____

Compliments of: _____

Price: _____ Arrival Date: _____

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Required by P.L. 86-559)			
1. TITLE OF PUBLICATION The Journal of the Florida Medical Association		2. DATE OF FILING Oct. 5, 1981	
3. FREQUENCY OF ISSUE Monthly		4. NUMBER OF ISSUES PUBLISHED Annually 12	
5. COMPLETE MAILING ADDRESS OF PUBLISHER (Street, City, County, State and ZIP Code) (Not printer)		6. ANNUAL SUBSCRIPTION PRICE \$15.00	
7. COMPLETE MAILING ADDRESS OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS (Not printer) 760 Riverside Avenue (P.O. Box 2411), Jacksonville, Florida 32203			
8. FULL NAMES AND COMPLETE MAILING ADDRESSES OF PUBLISHER, EDITOR AND MANAGING EDITOR (For form MUST NOT be blank)			
PUBLISHER (Name and Complete Mailing Address) Florida Medical Association, P.O. Box 2411, Jacksonville, FL 32203			
EDITOR (Name and Complete Mailing Address) Daniel B. Nunn, M.D., P.O. Box 2411, Jacksonville, Florida 32203			
MANAGING EDITOR (Name and Complete Mailing Address) Judie Constantin, P.O. Box 2411, Jacksonville, Florida 32203			
9. OWNERS (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent of more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a corporation or other entity, its name and address must be stated (Item must be completed). FULL NAME Florida Medical Association, Inc. COMPLETE MAILING ADDRESS P.O. Box 2411, Jacksonville, FL 32203			
10. FOR COMPLETION BY NONPROFIT ORGANIZATIONS AUTHORIZED TO MAIL AT SPECIAL RATES (Section 5115, Code 5013) The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes (Check one) <input checked="" type="checkbox"/> HAS NOT CHANGED DURING PRECEDING 12 MONTHS <input type="checkbox"/> HAS CHANGED DURING PRECEDING 12 MONTHS (If changed, publisher must submit explanation of change with this statement)			
11. EXTENT AND NATURE OF CIRCULATION		12. AVERAGE NUMBER OF COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	
A. TOTAL NO. COPIES (Net Press Run)		15,000	
B. PER CIRCULATION 1. SALES THROUGH DEALERS AND CARRIERS STREET VENDORS AND COUNTER SALES		13,800	
C. TOTAL SALES CIRCULATION (Sum of B and C)		13,800	
D. COPIES NOT DISTRIBUTED 1. OFFICE USE, LEFT OVER UNACCOUNTED SPOILED		1,200	
E. RETURN FROM NEWS DEPT.		1,000	
F. TOTAL (Sum of C, D, E, and F) (Should equal net press run shown in 11)		15,000	
13. I certify that the statements made by me above are correct and complete.		14. SIGNATURE AND TITLE OF EDITOR, PUBLISHER, BUSINESS MANAGER OR OWNER <i>Judie Constantin</i>	



I plan on living a long and healthy life, so I get regular cancer checkups. You should too. Contact your local ACS office for a free pamphlet on our new cancer checkup guidelines. Because if you're like me, you want to live long enough to do it all.

American Cancer Society

This space contributed as a public service

The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment



**CONVENTION
PRESS, INC.**

2111 NORTH LIBERTY ST.

**JACKSONVILLE,
FLORIDA 32206**

PHONE 904/354-5555

Deaths

Damron, John R., Fort Lauderdale; born 1925; University of Louisville, 1952; member AMA; died 1981.

Draper, Bruce, Tampa; born 1928; Yale University, 1950; died June 7, 1981.

Goddard, David W., Daytona Beach; born 1914; Duke University, 1939; member AMA; died July 27, 1981.

Haukohl, Robert S., Tampa; born 1916; Marquette University, 1940; member AMA; died May 9, 1981.

Higginbotham, S. Roy, Tampa; born 1914; Emory School of Medicine, 1940; died May 3, 1981.

Josephson, Richard A., Tampa; born 1944; Downstate (NY) Medical School, 1968; died July 13, 1981.

Kaminski, Theodore J., Melbourne; born 1918; University of Kentucky, 1940; member AMA; died September 17, 1981.

Rosenbaum, Herman G., Miami Beach; born 1902; University of Pittsburgh, 1927; member AMA; died 1981.

Rubin, Justin A., Fort Myers; born 1924; Hahnemann Medical College, 1952; member AMA; died August 14, 1981.

Shell, Paul George, Fort Lauderdale; born 1908; University of Tennessee, 1931; member AMA; died July 4, 1981.

Sims, John N. Sr., Fort Pierce; born 1916; University of Georgia, 1947; member AMA; died August 7, 1981.

Weeks, Theodore W. Jr., Fort Myers; born 1917; Duke University, 1942; member AMA; died July 30, 1981.

*We love the same country.
We care about the same things.
We dream the same dreams.
1981. The International Year
Of Disabled Persons.*

*President's Committee on
Employment of the Handicapped
Washington, D.C. 20210
The School of Visual Arts
Public Advertising System*

Christmas
Seals®
fight
lung disease



Space contributed by the publisher as a public service



Florida
Medical
Center

Announces The Annual
Coronary Artery Disease Seminar

To Be Held At
THE INVERRARY HILTON, FT. LAUDERDALE, FLORIDA
FEBRUARY 25-27, 1982

The program is designed to present the physician caring for cardiac patients the views and concepts of nationally recognized authorities in heart disease. *Registration Fee \$300.00.*

GUEST FACULTY

Agustin Castellanos, M.D.	Spencer King, M.D.
Lawrence Cohen, M.D.	Floyd Loop, M.D.
Richard Conti, M.D.	August Miale, M.D.
Richard Gorlin, M.D.	Robert Myerburg, M.D.
Herman Hellerstein, M.D.	Peter Rentrop, M.D.
Leonard Holman, M.D.	Simon Stiertzer, M.D.

WRITE TO

TOM FUTCH, *Administrator Professional Services*
Florida Medical Center
5000 W. Oakland Park Blvd., Fort Lauderdale, Florida 33313
(305) 735-6000, Ext. 4104

An apple a day won't keep alcoholism away!

The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

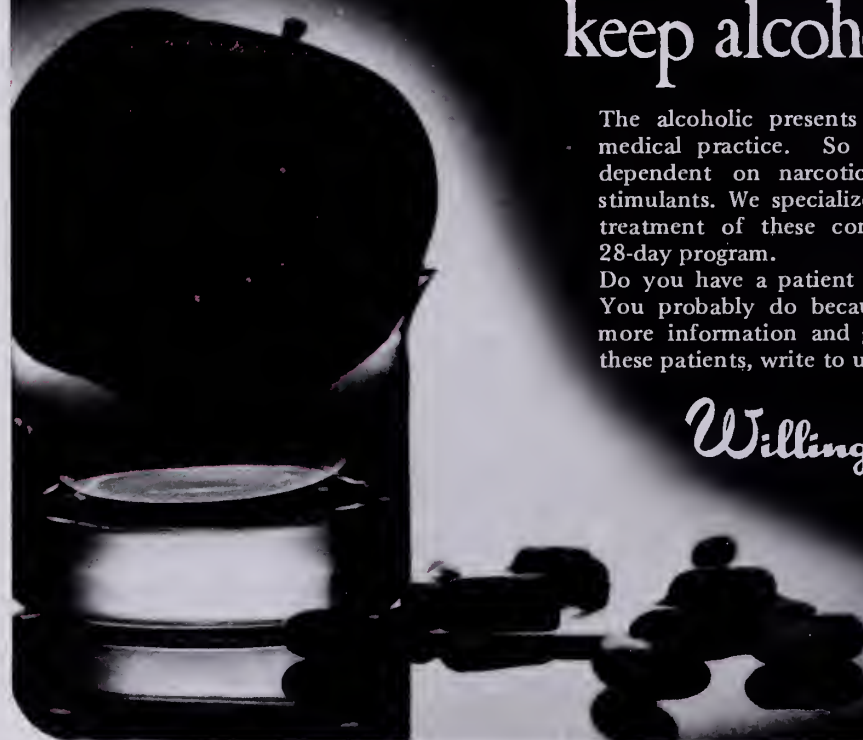
Do you have a patient who needs this kind of help? You probably do because the illness is sneaky. For more information and guidelines on how to identify these patients, write to us.

Willingway Hospital

311 JONES MILL ROAD
STATESBORO, GA. 30458

(912) 764-6236

J.C.A.H. ACCREDITED



CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

MEDICAL OPHTHALMOLOGIST wanted for busy practice. No refraction or contact lens fitting. Ideal location in East Coast of Florida. Jonathan Chua, M.D., 100 N.E. 5th Ave., Delray Beach, Florida 33444, (305) 276-4181.

FLORIDA — Aggressive group, fee-for-service, malpractice, group health insurance, teaching, EMS, opportunity for advancement. Contact Steve Watsky, M.D., 707 40th Street West, Palmetto, Florida 33561, (813) 722-1722 or P. Fagan Jr., M.D., Post Office Box 9639-FL, Marina Del Rey, California 90291, (213) 822-1312.

PHYSICIANS WANTED! Non-clinical disability evaluation, medical consultation for Social Security. Fulltime 40 hour work week. Knowledge of electrocardiographic interpretation desirable. G. M. Davis, State Medical Consultant, 3437 Lawton Road, Suite 127, Orlando, Florida 32803; (305) 896-4691.

EMERGENCY DEPARTMENT PHYSICIAN needed to join established group in North Central Florida. Paid malpractice, profit sharing and pension plan second year. 28 hour work week. Good salary first year. Contact R. W. Carr, M.D., 9900 N.W. 115 Avenue, Ocala, Florida 32671.

LOCUM TENENS in Diagnostic Radiology with Ultrasound capabilities. Two week minimum. Florida license required. ABR certified or eligible. Send C.V. with inquiry to Drs. Plenge and Bedoya, 600 North Church Street, Lake City, Florida 32055, or call collect after hours (904) 755-2235.

OBSTETRICIAN / GYNECOLOGIST — South Central Florida — Excellent solo opportunity with good coverage for OB/GYN with Florida license in community of 25,000 with a service area population of 50,000. New 75 bed, full service hospital. Office space available in new professional building next to hospital. Area unsurpassed in natural beauty and recreational activities. Extremely high earnings potential. Send C.V. to Jim Butler; Manager, Medical Relations, Hospital Corp. of America, One Park Plaza, Nashville, Tennessee 37203, or call toll free (800) 251-2561.

RAPIDLY GROWING 23 man multi-specialty group on Florida's Treasure Coast, will add a well trained Family Practitioner to its five man Family Practice Department. Please send C.V. to C-1065, P.O. Box 2411, Jacksonville, Florida 32203.

EMERGENCY MEDICINE: Clinical and Directorship positions available in moderate volume emergency department located in Brooksville. Excellent income, flexible scheduling without on-call duty, and paid malpractice insurance. For details, send credentials in confidence to Susan Haberman, 1111 N. Westshore Blvd., Suite 211, Tampa, Florida 33607; or call collect (813) 870-2356.

WANTED: NON-INVASIVE CARDIOLOGIST to join well established high caliber internal medicine group in Florida. Private practice affiliated with excellent hospital with stress, nuclear and echo. Lucrative. Delightful location. Contact: C-1068, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST / Board Certified or Board Eligible. Group of 16 Board Certified Internists, several subspecialty certified, seek association with a Board Certified or Board Eligible Internist. Excellent academic stimulus; financial security with progressive incentive. No investment necessary. Beautiful area of Palm Beach, Florida. Please send CV to Leonard W. Appleby, M.D., The Lake Worth Medical Center, 518 N. Federal Highway, Lake Worth, Florida 33460.

INTERNIST — CARDIOLOGIST: Three man practice seeks badly needed associate with immediate availability possible. Excellent opportunity in well established Internal Medicine, non-invasive Cardiology practice in Coral Gables, Florida. Reply C-1036, P.O. Box 2411, Jacksonville, Florida 32203.

ANESTHESIOLOGY — Director required by licensed Ambulatory Surgical Center. Contract terms commensurate with credentials. Excellent benefit package including option to participate in ownership. Send resume, three references, and salary requirements to AMI, 1661 Phillips Road, Tallahassee, Florida 32308.

PEDIATRICIAN — BC/BE to join an active and growing primary care practice. Initially to share office and call. Office is next to Flagler Hospital. Financial arrangements negotiable. Florida license required. Write or call Robert K. Wise, M.D., 11 Tremerton Street, St. Augustine, Florida 32084. Phone (904) 829-6591.

FAMILY PHYSICIAN needed for solo or group type practice. Fee for services and guaranteed referrals. Brand new and well equipped office building. Located on one of Florida's finest gulf and sun coast communities. Center for cultural, educational and recreational resources. Good opportunity for right person. For more information contact: Post Office Box 834 Bradenton, Florida 33506.

PHYSICIANS WANTED to form medical-dental complex, either condominium or individual buildings. Special interest rates well below prime rate may be available for total financing. Beautiful Central Florida location. Write: Dr. M. Max Weaver, One Doctors Lane, Lake Wales, Florida 33853 or call (813) 676-8536.

PULMONARY INTERNIST/BOARD CERTIFIED or Board Eligible. Location: Fast growing area of Southeast Florida. Expanding group of physicians seeks association with Board certified or Board eligible Pulmonary Internist. Please send curriculum vitae to C-1072, Post Office Box 2411, Jacksonville, Florida 32203.

FLORIDA — Family Physicians for rural or metropolitan emergency departments. Full or parttime. Immediate openings. Florida license required. Contact Dr. Julius Garner or Dora Harrison, Suite 100, 238 Westmonte Road, Altamonte Springs, Florida 32701. Phone (305) 788-0786.

FP NEEDED to associate with two other FPs in office in north Palm Beach County, (Jupiter-Tequesta area). Also space for ophthalmologist, dermatologist or surgeon. Coverage and assistance available. Two open staff hospitals nearby for qualified M.D.s. (305) 746-2033 or (305) 747-0279.

IMMEDIATE POSITION — INTERNIST, preferably with subspecialty in Cardiology or Gastroenterology to join established busy Internist-Gastroenterologist in Hollywood, Florida. Contact Louis D. Bennett, M.D., 3829 Hollywood Blvd., Hollywood, Florida 33021 or phone (305) 966-8200.

PEDIATRICIAN desired to join established solo practice boarded pediatrician in growing west central Florida area on or after July 1982. David W. Powers, M.D., Route 6, 415 N. Central Ave., Inverness, Florida 32650. Phone (904) 726-8660.

WANTED: Retired physician coverage for new non-profit outpatient clinic in British Turks and Caicos Islands — 550 air miles from Miami. Will seriously consider contract with Family Practice or Emergency physician group, or as individuals with rotation schedule. Desirable to have same physician three months or repeat rotation pattern of 3-4 persons/year. Stipend plus housing and use of automobile. Physician pays own travel expenses. Malpractice coverage with Lloyds. Adequate time for study, writing and relaxing. Beautiful sands, sea, scuba and fishing. Call (616) 238-9853 from 8 a.m. to 5 p.m.; (616) 238-7244 evenings. Send inquiries to Providenciales Health-Medical Center Foundation, P.O. Box 117, Indian River, Michigan 49749.

PRIMARY CARE: Family Practitioners, Internists and Pediatricians are being sought for staff positions with INA Healthplan. Excellent opportunity to grow with this prepaid health plan in the Tampa Bay area. Come enjoy the living on Florida's Suncoast. Send C.V. to: Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516.

WANTED: GENERAL INTERNIST, Board Eligible or qualified, with Florida license to share long established active practice and expenses. No initial investment. Will subsidize if necessary. Central Florida east coast city. Send resume and photo to C-1073, Post Office Box 2411, Jacksonville, Florida 32203.

WE ARE LOOKING for a Florida licensed physician to help us provide quality outpatient health care in the Tampa community. We have two minor emergency walk-in and family practice clinics, with fully staffed lab and x-ray facilities; good specialty back-up. Approximately 40 hours weekly, no weekends, no hospital practice. Excellent salary, good benefits and vacations. Please send all inquiries to: Bay Medical Center, P.O. Box 18913, Tampa, Florida 33609.

FAMILY PRACTITIONER OR INTERNIST needed to join staff of a Family Medical Center in North Florida. Excellent opportunity for professional and economic growth. Respond with CV to: Susan Masterson, Emergency Medical Services Associates, Inc., 8200 W. Sunrise Blvd., Building C, Plantation, Florida 33322, or phone (800) 327-0413. In Florida call (305) 472-6922.

EMERGENCY PHYSICIAN positions available in Fort Lauderdale area. Minimum guarantee, malpractice paid, opportunity to develop emergency medical practice in pleasant environment within a supportive hospital setting. Please send resume or contact NEEMA Emergency Medical, 399 Market Street, Suite 400, Philadelphia, Pennsylvania 19106. (800) 523-0776.

PSYCHIATRIST needed for a full-time position with our Outpatient Program, 15-bed Crisis Stabilization Unit and 90-bed Geriatric Residential Center. Florida license (or eligibility) required. Private practice and consulting opportunity available. Responsibilities include intake diagnosis, treatment and discharge, rotating on-call duty and outpatient counseling for psychiatric medications. Salary range good. For more information, contact the Personnel Dept., Santa Rosa County Mental Health and Rehabilitation Facility, Inc., 400 Stewart St., N.E., Milton, Florida 32570. EOE.

PHYSICIAN WANTED: OB/GYN, Central Florida (Lake County), one hour from each coast, 45 minutes from Disney World. Office adjacent to established female pediatrician. Contact: Mary M. Anderson, M.D., 500 N. Burleigh Blvd., Tavares, Florida 32778. (904) 343-1418.

PHYSICIAN WANTED: seeking a Board qualified specialist in Family Medicine to join established practice in Tampa as a salaried employee for a 40-hour week at good salary. Must agree to a 50-week commitment. Must have current Florida and DEA licenses. Call (813) 971-7723.

TAMPA BAY AREA, Family Practice, part or fulltime, E. House, M.D., (904) 796-9425, Brooksville; you choose your workload.

Situations Wanted

31 YEAR OLD BOARD CERTIFIED; well trained in all aspects of Dermatology, and Dermatologic Surgery. Looking for a full or part time position in Florida. Reply: Jack Albert, M.D., P.O. Box JJ, Big Stone Gap, Virginia 24219. (703) 523-2000 (10:00 - 4:00 work), (703) 523-3258 (home). Available after November 1, 1981.

UROLOGIST, 31, American Graduate, Florida license, Board Eligible, excellent training at large New York City Medical Center. Desires group practice or partnership in South Florida. Phone: (212) 289-7235, evenings.

EXPERIENCED INTERNIST / CARDIOLOGIST seeks full or parttime salaried position with hospital or industry involving administration and/or clinical duties. Age 46. Available December 1981. Call Dr. R. Kline (305) 532-9615.

UROLOGIST, trained at major New York medical center with one year of pediatric urology fellowship at Toronto. Florida license, available immediately. Call (212) 282-3250.

UROLOGIST AND ANESTHESIOLOGIST, husband and wife, excellent university qualifications, are looking for opportunities beginning July 1982 in a semi-urban community. Solo or partnership offers welcome. Reply to C-1070, Post Office Box 2411, Jacksonville, Florida 32203.

RHEUMATOLOGIST — ABIM, BE rheumatology, seeks partnership or group practice, Broward, Palm Beach or Dade counties. Reply: C-1071, Post Office Box 2411, Jacksonville, Florida 32203.

UNIVERSITY TRAINED GENERAL SURGEON currently doing a fellowship in vascular surgery seeks position. Contact Dr. Ruben Delgado, Spring Ridge M-26, Whitehall, Pennsylvania 18052. Available August 1982.

Practices Available

ACTIVE GENERAL PRACTICE established for 11 years, for sale due to retirement. Well-equipped office, located close to Coral Reef General Hospital, Miami, Florida, will be available December 1981. Reasonable terms. Contact George J. Fiala, M.D., 9875 East Fern Street, Miami, Florida 33157. Telephone (305) 238-8561.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

LAGO VISTA EXECUTIVE CENTER, 8019 N. Himes Avenue, Suite 300, Tampa, Florida 33614. 1,500 square feet, suitable for doctor. Quiet, pleasant atmosphere, overlooking landscaped lake. Convenient location. (813) 933-5100.

CONDOMINIUM for rent St. Thomas U.S.V.I. on the Caribbean, two bedrooms, two bathrooms, three pools, free tennis, reduced airfares. Still available for Perinatology meeting November 15th through the 21st. List of other meetings available. Call Dr. Blondy collect at (313) 478-2739.

SKIING: Winter wonderland, luxury chalet, 4 bedrooms, 4 baths, complete recreational level. Beech Mountain, North Carolina. Information and rates: P.O. Box 10064, Jacksonville, Florida 32207.

NEW OFFICES AVAILABLE — Fast growing area of U.C.F. Preconstruction value! Medical and other Health professionals reply (305) 647-7170 or (305) 644-1707. Estimated \$70-80/square foot.

CENTRAL FLORIDA — Ideal for group practice — three or more physicians. Colonial-type office building (approximately 4,000 square feet) with ample parking. All on four lots (33 x 133 each). Fully equipped including lab, x-ray and minor surgery. Located two blocks from Waterman Hospital, a fully accredited 150 bed general hospital with open staff for qualified M.D.s or D.O.s. Price quote on request. Terms negotiable. Contact Dr. Louis R. Bowen, Box 69, Eustis, Florida 32726. (904) 357-4101, (904) 357-3756.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Co., 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

CONTEMPORARY PAINTINGS and works on paper for private or corporate collectors. Fine prints by major artists. Special exhibitions October-May. Hodgell Hartman Gallery, 48 South Palm Avenue, Sarasota, Florida 33577. (813) 955-4785.

Equipment

WE BUY, SELL, LEASE new and used medical instrumentation — EKG's, Laboratory, Holters, Scanners, Stress Test, Echocardiographs, etc. Contact: New Life Systems, Inc., Edgar Bentolila, P.O. Box 8767, Coral Springs, Florida 33065. Phone (305) 753-9961.

TECA Model M EMG machine. Used 10 months. All accessories with mobile stand. Excellent condition. 50% off list price for quick sale. \$4,000.00 cash. Phone (813) 687-4311.

WHEELCHAIR, STRETCHERS with wheels and sides, Instrument and I.V. stands, carts, more. All one year new and mint. Best offer. Dr. S. Rosen (305) 475-8423 Ft. Lauderdale.

Services

DOCTOR, WE KNOW YOUR BUSINESS. With 27 years experience as a Hospital Administrator, Bill Bishop, F.A.C.H.A., understands your needs! He can help you find qualified candidates for that hard to fill position of Office Manager, or Clinic Manager. Bill Bishop and Associates, Inc., Health Care Executive Search Consultants, 1045 Riverside Avenue, Jacksonville, Florida 32204, (904) 354-1050.

Miscellaneous

32' ENDEAVOR SAILBOAT (1980) — Fully equipped plus many extras — RDF, VHF, CB, auto pilot and five man Avon dinghy, etc. Priced at 20% below replacement. Physician owned and maintained. Financing available to right person. \$46,000. Call (904) 763-4838 or (812) 853-3847.

Meetings

STEAMBOAT SPRINGS, COLORADO — Current Concepts in Pain Management and Current Concepts in Office Management (and the New Tax Law). Structured so spouse can attend. Dec. 20-25, 1981, Feb. 14-19, 1982, July 18-23, 1982. Fee — \$250.00, plus \$150.00 for spouse. For information contact Current Concept Seminars, 9400 S. Dadeland Blvd., Suite 300, Miami, Florida 33156. (305) 666-0401.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Brian Wallach heads his own Insurance Company, has a wife, two children and is blind.

President's Committee on Employment of the Handicapped Washington, D.C. 20210

1981. The International Year of Disabled Persons.

Advertisers

Boots Pharmaceuticals		Eli Lilly & Company	
Rufen	902a	Keflex	881
Ru-Tuss	866a		
Brown Pharmaceuticals		Medi-Serv South, Inc.	
Cerebro-Nicin	930	Service	880
Lipo-Nicin	931		
Android	934	Merrell Dow Pharmaceuticals	
Burroughs Wellcome		Bentyl	926
Neosporin Topicals	933	Quinamm	918a
Zyloprim	925		
Cary Martin		National Medical Enterprises	
Decorating	922	Service	866
Convention Press		PIMCO-RLR	
Service	937	Service	882
Florida Medical Center		Roche Laboratories	
Service	938	Valium	864
Florida Medical Foundation		Librax	918a
Citrus and Seafood	936	Limbitrol	943
Florida National Banks		Smith Kline & French	
Service	876	Dyazide	918a
Florida Physicians Insurance		University of Miami	
Service	862	Meetings	879, 928, 932
Geriatric Pharmaceutical Co.		The Wetzel Company	
B-C-Bid	872	Service	898
Hospital Corporation of America		Willingway Hospital	
Recruitment	934	Service	938
Jupiter Lakes Medical Park		Wyeth Laboratories	
Real Estate	878	Cyclapen-W	870
Lightcom, Inc.		Equagesic	898a
Communication	935	Wygesic	898a
		Ativan Oral	876

Florida Medical Association Officers and Council Chairmen

Officers

Sanford A. Mullen, M.D., Jacksonville, President
Robert E. Windom, M.D., Sarasota, President-Elect
Gerold L. Schiebler, M.D., Gainesville, Vice President
Luis M. Perez, M.D., Sanford, Secretary
J. Russell Forlaw, M.D., Boynton Beach, Treasurer
T. Byron Thames, M.D., Orlando, Immediate Past-President
James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Charles P. Hayes, M.D., Jacksonville, Health Care Financing
Joseph T. Ostroski, M.D., Miami, Medical Services
Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
Arthur L. Eberly, M.D., Lighthouse Point, Specialty Medicine

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

DECEMBER 1981 • VOL 68 • NO. 12



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

JAN 11 1982

WHY INSURE WITH A PHYSICIAN-OWNED COMPANY?

- Physician companies are run for their members; Commercial carriers operate for profit.
- Will commercial companies leave physicians bare as happened in 1975?
- Committed to providing malpractice coverage on an actuarially sound basis at an affordable price.
- The lowest premium today may not prove to be the wisest investment in the future.

FLORIDA
PHYSICIANS'
INSURANCE

RECIPROCAL

1000 Riverside Ave. / P. O. Box 40198 / Jacksonville, FL 32203

Telephone (904) 354-5910 / Wats 1-800-342-8349



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

DECEMBER 1981 • VOL 68 • NO. 12 (ISSN 0015-4148)

Editor

Daniel B. Nunn, M.D.

Associate Editors

Clyde M. Collins, M.D.
E. Charlton Prather, M.D.

Assistant Editors

Francis C. Coleman, M.D.
James K. Conn, M.D.
Lee A. Fischer, M.D.
Henry L. Harrell Jr., M.D.
Norman M. Kenyon, M.D.
(from Board of Governors)
Edward Pedrero Jr., M.D.

Historical Editor

William M. Straight, M.D.

Book Review Editor

F. Norman Vickers, M.D.

Executive Editor

Edward D. Hagan

Managing Editor

Judie Hill Constantin

Consulting Editorial Staff

Fuad S. Ashkar, M.D.	Karl J. Kramer, M.D.
Thomas D. Bartley, M.D.	R. G. Lacsamana, M.D.
Robert L. Batey, M.D.	Richard F. Lockey, M.D.
Pierre J. Bouis Jr., M.D.	Philander D. Morgan, M.D.
Ms. Deborah B. Wilbur	George Morris, M.D.
William T. Branch, M.D.	George A. Neder Jr., M.D.
Miguel A. Brito, Jr.	Richard S. Panush, M.D.
Elmer B. Campbell, M.D.	R. A. Penalver, M.D.
Manuel L. Carbonell, M.D.	John K. Petrakis, M.D.
Ronald W. Case, M.D.	Phillip B. Phillips, M.D.
Toni Charneco	Michael R. Redmond, M.D.
Louis E. Cimino, M.D.	Albert L. Rhoton, M.D.
Charles Craig, M.D.	James F. Richards Jr., M.D.
R. Jay Cummings Jr., M.D.	Arvey I. Rogers, M.D.
Raul deVelasco, M.D.	William J. Romanos Jr., M.D.
James E. Deming	Lees M. Schadel, M.D.
Pablo Enriquez, M.D.	Frederick W. Schert, M.D.
Robert F. Feltman, M.D.	Guy T. Selander, M.D.
Richard Feinstein, M.D.	Roberto A. Sosa, M.D.
Lawrence M. Fishman, M.D.	John Stone, M.D.
Allan L. Goldman, M.D.	Robert H. Threlkel, M.D.
Henry L. Harrell, M.D.	Benjamin E. Victorica, M.D.
Allan Herskowitz, M.D.	Thomas M. Wiley, M.D.
James T. Howell, M.D.	Charles D. Williams, M.D.
Rubin Klein, M.D.	Frederic C. Wurtzel, M.D.

Subscription Rate: \$15.00 per year, single copy, \$1.50 (plus 4% sales tax within State of Florida except special issues which are \$2.50 plus tax). Address: The Journal of the Florida Medical Association, Inc., P.O. Box 2411, 760 Riverside Avenue, Jacksonville, Florida 32203. Telephone: (904) 356-1571. Microfilm editions available beginning with 1967 volume from University Microfilm, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The Journal, its editors and the Florida Medical Association, Inc. are not responsible for the opinions and statements of its contributors and advertisers. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103 Act of Congress of October 3, 1917; authorized October 16, 1918. Second-class postage at Jacksonville, Florida.

Copyright 1981 by Florida Medical Association, Inc.

Contents

Scientific Articles

- 965 Nongonoccal Urethritis
A Clinical Problem of the 80's
*Pierre J. Bouis, Jr., M.D.,
Anthony M. Messina, M.D. and
Mitchel Hoffman, M.D.*
- 968 Spinal Cord Injury in South Florida
*Newton C. McCollough III, M.D.,
Barth A. Green, M.D., K. John Klose, Ph.D.,
Myron L. Goldberg, Ph.D. and Caryl Klose, R.N.*
- 974 Blepharospasm
Jonathan D. Trobe, M.D.
- 980 Echocardiographic Evaluation in Surgically
Treated Infective Endocarditis
*W. Daniel Doty, M.D., Abe W. Friedman, M.D. and
Robert Samuel Cromartie III, M.D.*
- 986 Isolated Rupture of Extensor Pollicus
Longus Case Report
Issa F. Baroudi, M.D.

Special Articles

- 989 The FMA Retired Lives Reserve:
An Innovative Plan to Insure Your Future
Sanford A. Mullen, M.D.
- 991 Agent Orange: What's It All About?
*Franklin P. Flowers, M.D., Neil A. Fenske, M.D.
and Pattye A. Whisman, M.D.*

Editorials

- 959 A Christmas Hope for the Future
Clyde M. Collins, M.D.
- 960 Wounded Healers
Frank G. Slaughter, M.D.
- 961 The First Domino to Fall
William H. Houston, M.D.
- 962 Needs for a School of Public Health
in the State of Florida
Jorge Deju, M.D., M.P.H.

Departments


- 953 The President's Page
A Holiday Message
Sanford A. Mullen, M.D.
- 993 Notes and News
- 1000 FMA Auxiliary
Aging: A Positive Process
- 1001 Worth Repeating . . .
*Can Big Government and Medicine Ever Find Happiness
Together?
RVS, Specialty Screens, PATCO and Medicine*
- 999 Book Reviews
- 1004 Correspondence
- 1005 Meetings
- 1011 Index to Volume 68
- 1015 Classified Advertising
- 1018 Index to Advertisers
- 1018 FMA Officers and Council Chairmen

Cover

The cover this month, chosen by Mrs. Daniel B. Nunn (Gloria) of Jacksonville, focuses on this holiday season of peace, joy and love. The JFMA is grateful to the Riverside Presbyterian Church, Jacksonville, for allowing us to feature one of the church's stained glass windows, photographed by Bill Elsner.

**THE PATIENT THINKS
HE HAS HEART TROUBLE...**





...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM®

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED
THE PATIENT NEEDS IT



Please see summary of product information on the following page.

VALIUM® (diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10;* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701

†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110



ROCHE PRODUCTS INC
Manati, Puerto Rico 00701

When we help establish your practice, your primary cares will be solved.

To establish a Primary Care practice, your first need is to solve your primary cares.

That's where we come in.

We can offer you a choice of over 60 well equipped acute care hospitals coast to coast. We can offer you selected financial assistance. We can offer you management consulting.

So whether you're interested in a solo, partnership, or group practice, contact NME today.

We'll help establish your practice. And solve your primary cares.

For further information, contact:

Raymond C. Prulitt, Director, Physician Relations
National Medical Enterprises
11620 Wilshire Blvd., Los Angeles, California 90025.

Call Toll-Free 800-421-7470
or collect (213) 479-5526.

NATIONAL MEDICAL
ENTERPRISES, INC.



"The Total Health Care Company."

An Equal Opportunity Employer M/F

"HCA thought I would need a partner in a year. It only took four months."

Dr. Jason H. Brazee, M.D., Gaffney, S.C.

"I tried several sources to locate the practice I wanted. HCA has an organized, sensitive approach in locating suitable practices for physicians. I indicated my needs and they found Gaffney. No attempt to sell me on a location that

wasn't right. The practice was so successful that within four months I needed an internist to join me. HCA found him."

"Now we have a rapidly-growing, single-specialty partnership with tremendous community support. At this rate, we'll probably need another physician in less than a year. And we'll go back to HCA. I highly recommend them." For information on how HCA can assist you, send your *curriculum vitae* and geographical and professional preferences, in confidence, to: Charles M. Wooden, Professional Relations, HCA, P.O. Box 550, Nashville, TN 37202. Or call toll-free, 1-800-251-2561. There is no cost or obligation.

HCA Hospital Corporation of America



Florida Medical Center

Announces The Annual

Coronary Artery Disease Seminar

To Be Held At

THE INVERRARY HILTON, FT. LAUDERDALE, FLORIDA

FEBRUARY 25-27, 1982

The program is designed to present the physician caring for cardiac patients the views and concepts of nationally recognized authorities in heart disease. *Registration Fee \$300.00*

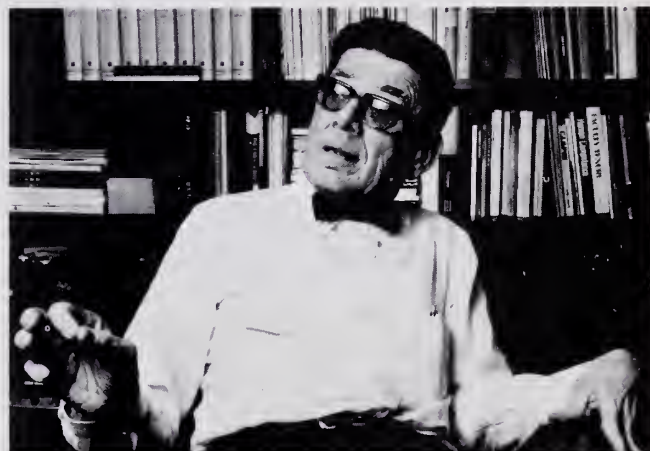
GUEST FACULTY

Agustin Castellanos, M.D.
Lawrence Cohen, M.D.
Richard Conti, M.D.
Richard Gorlin, M.D.
Herman Hellerstein, M.D.
Leonard Holman, M.D.

Spencer King, M.D.
Floyd Loop, M.D.
August Miale, M.D.
Robert Myerburg, M.D.
Peter Rentrop, M.D.
Simon Stertzer, M.D.

WRITE TO

TOM FUTCH, *Administrator Professional Services*
Florida Medical Center
5000 W. Oakland Park Blvd., Fort Lauderdale, Florida 33313
(305) 735-6000, Ext. 4104

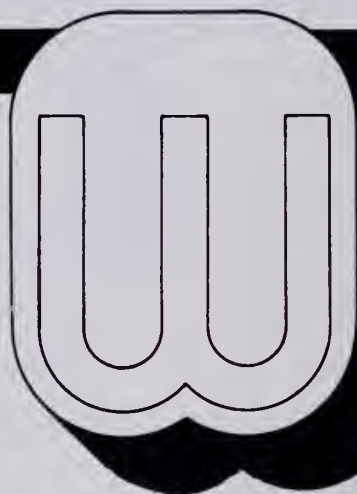


Harold Yuker is Provost of Hofstra University. He has cerebral palsy.

President's Committee on
Employment of the Handicapped
Washington, D.C. 20210

Produced by The School of Visual Arts Public Advertising System

**REINSURANCE
BROKERS for
Florida Physicians
Insurance Reciprocal
—serving physicians
throughout Florida**



**The
Wetzel
Company,
Inc.**

P.O. Box 66452 • Houston, Texas 77006



President's Page

A Holiday Message

As the holiday season approaches, I find that I am well into the second half of my year as your President. During the months that I have been privileged to serve in this capacity, I have learned a great deal about the abilities and the good deeds of the doctors of the State of Florida.

Thus far I have had the opportunity to visit several county medical societies and am presently scheduled to visit with other county societies as well as with specialty groups. Each one of the visits thus far has been a rewarding educational experience for me. I am sure that my future visits will continue this educational experience.

In my comments to you this month, I would like to ask you to use the holiday season to pause for a moment and consider how fortunate we are to be practicing medicine in the great State of Florida, a part of the most wonderful country in the world. In spite of the problems we face in our daily practice in this era of litigious consumerism, governmental interference, and unrelenting encroachment by non-medical practitioners, the environment in which we practice is far better than that of any other part of the world so far as I can determine. We should take time to recognize the many good things about the practice of medicine in our country. At the same time we must also realize that we must continue to devote a significant part of our energies to the effort to protect the practice of medicine from the many outside forces which would destroy the high standards and quality of medical practice which the people of the United States enjoy.

During this holiday season I would also suggest that you take time to be more closely a part of your family. All of us know that the practice of medicine takes us away

from our families far too much for our own good. In the great holiday seasons of Christmas and Hanukkah we have a wonderful opportunity to think more about our responsibilities to our families.

The stressful life that is so much a part of the practice of medicine has been the concern of many thoughtful individuals in recent years. My predecessor as president of the FMA, Dr. T. Byron Thames of Orlando, used "Stress and Lifestyle" as his theme for his year as president. Among other results of this theme, a special issue of *The Journal of the Florida Medical Association* was published in April of 1981. This described many of the aspects of stress that doctors face and suggested solutions to many of them. Although it is a rather simplistic approach to a complex problem, I would suggest that a pause to become involved with one's family and to be an active part of this great holiday season would be one very effective means of reducing the stress related to the practice of medicine.

In this happy holiday season I wish the best to all of you. I look forward to meeting many of you as I continue my travels around the state. I hope that you will be present in large numbers at the leadership conference in Orlando on January 30 and 31 at which time we will come to grips with some of the problems of the financing of health care. And you can be sure that I am anticipating being with you at our annual meeting this May in Hollywood. But for the moment, let us pause from the rigors of our activities and enjoy the holiday season. To each of you a Merry Christmas and Joyous Hanukkah and a Most Happy and Prosperous 1982. May all of your fondest dreams and wishes come true.

Sanford A. Phullen, M.D.

There's more to ZYLOPRIM[®] than (allopurinol).



- From Burroughs Wellcome Co. – the discoverer and developer of allopurinol
- Patient starter/conversion kits available for easy titration of initial dosage
- Patient compliance pamphlets available
- Continuing medical education materials available for physicians



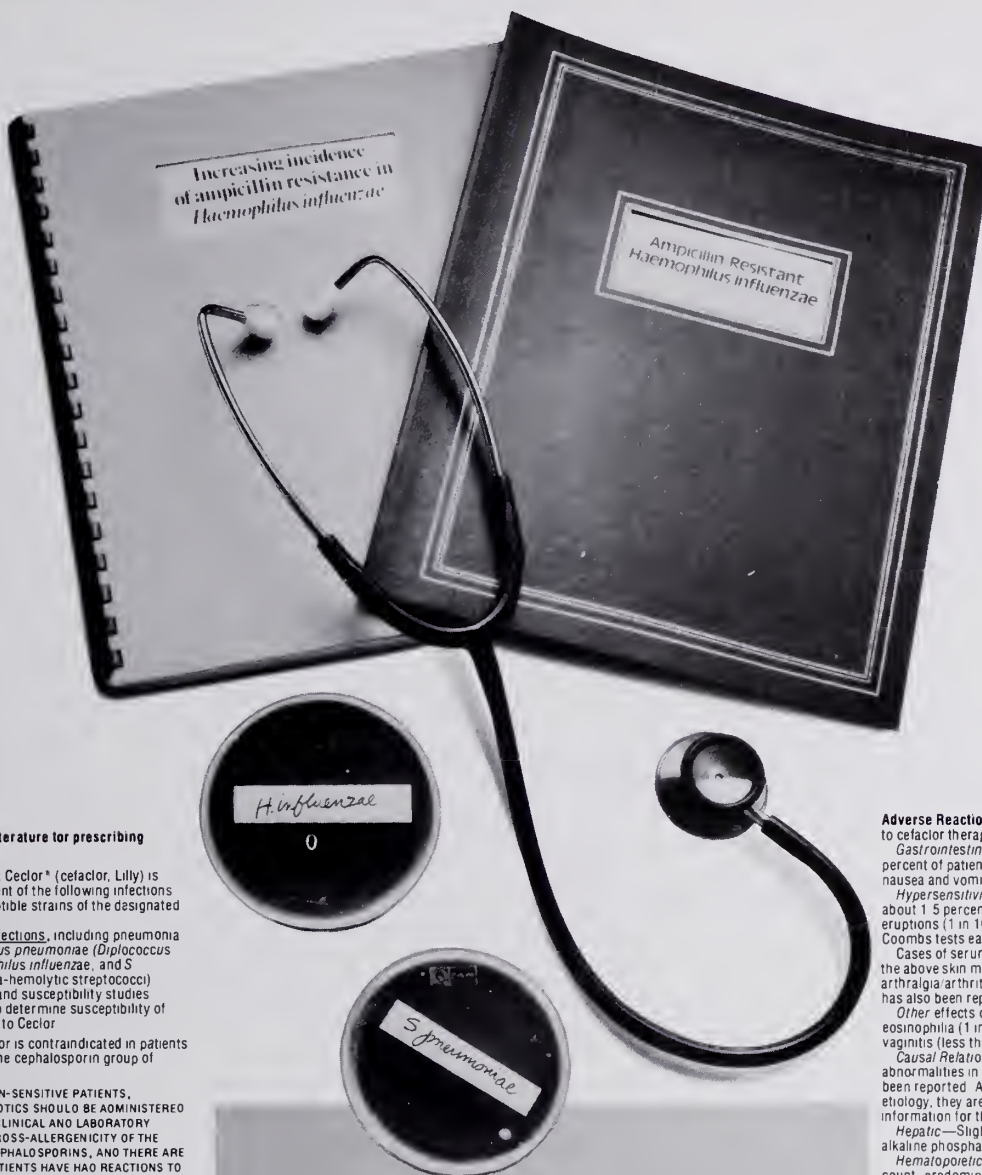
Prescribe for your patients as you would for yourself.

*Write "D.A. W.," "No Sub," or "Medically Necessary,"
as your state requires, to make sure
your patient receives the original allopurinol.*



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefaclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindication: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy:—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy:—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

Cefaclor®

cefaclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain:—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic:—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic:—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal:—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

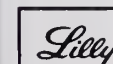
*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975
2. Antimicrob. Agents Chemother., 11: 470, 1977
3. Antimicrob. Agents Chemother., 13: 584, 1978
4. Antimicrob. Agents Chemother., 12: 490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), 11: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

100061

The FLORIDA PRINTER WITH EVERYTHING

- Financial Printing
- Quality Color Work
- Catalogs
- Brochures
- Headliners
- Hot Metal Composition
- Photocomposition
- Web Offset
- Sheet Fed Offset
- Letterpress
- Full Bindery Facilities
- Perfect Binding
- Automatic Mailing Equipment



**CONVENTION
PRESS, INC.**

2111 NORTH LIBERTY ST.
**JACKSONVILLE,
FLORIDA 32206**

PHONE 904/354-5555

Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Branchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of non-susceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis and Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.

†depending on severity

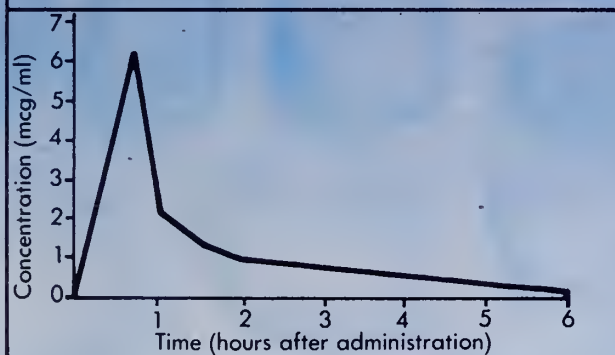
How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

Wyeth Laboratories
Philadelphia, Pa 19101

Half the dose
is absorbed in 9 minutes!
compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T_{1/2} values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

Copyright © 1980, Wyeth Laboratories. All rights reserved.

Wyeth Laboratories • Philadelphia, Pa. 19101



Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.[†]

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

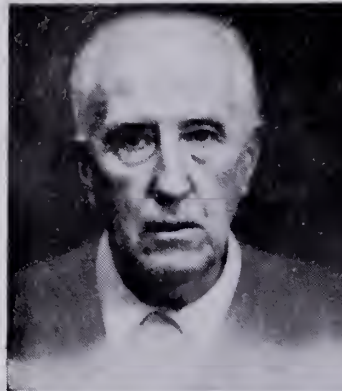
[†]Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W
(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW
NAME



Dual-action therapy to enhance mental and physical activity in the elderly.

MENICTM

PENTYLENETETRAZOL 100 mg • NICOTINIC ACID 50 mg

Menic combines the proven effectiveness of cortical stimulation and cerebral vasodilation, reducing mental confusion, faulty memory and negative social behavior often associated with the senility syndrome.

DOSAGE: Two tablets after each meal.

SIDE EFFECTS: Occasionally flushing and pruritus associated with niacin administration.

PRECAUTIONS: Use with caution in patients with low convulsive threshold, focal brain lesions, severely impaired liver function,

peptic ulcer, diabetes, and gall bladder or liver diseases. Niacin may potentiate hypotensive drugs, phenothiazine derivatives and inactivate fibrinolysin.

CONTRAINDICATIONS: There are no known contraindications to Menic.



GERIATRIC PHARMACEUTICAL CORP. 397 JERICO TURNPIKE, FLORAL PARK, N.Y. 11001
PIONEERS IN GERIATRIC RESEARCH . . . DEVELOPERS AND SUPPLIERS OF CEVI-BID • GAYSAL • ISO-BID

Physicians' Confidential Assistance

Call (305) 667-8717

. . . if you, or a physician you know,
have an alcohol or other drug-
related problem.



FMA Committee on Impaired Physicians

A Christmas Hope for the Future

Just for awhile, Lord, let me be a child again. I remember those feelings of long ago but they slipped away one day. If I just might once again run as fast as I could, just for the fun of feeling the cool air blow in my face — or climb a tree to look at the sky-blue eggs in a robin's nest — or go to bed wide awake on Christmas Eve, believing but not understanding how Santa Claus could squeeze down the small chimney into our living room.

In my mind's eye, sitting in church Sunday night I can again vividly see the nativity pageant as Mary and Joseph, behind a roughly hewn manger, gazed in awe-some pride on their newborn son and the wise men, in colorful robes and turbans, looked for the Star in the East as they began their long walk down the aisle in their ever continuous search for the Child of truth and love.

I remember days beginning with laughing expectancy, fortunately free from fear, want and hunger, trusting everyone, ideally loving and respecting every human associate, unaware that many children go to bed hungry or know nothing of family love, Santa Claus, honesty and integrity or the Christ child. Today millions of adults alive in this world are unaware of the child lurking not too far beneath their skin — a child who eats too much because he craves the sweetness of affection, a child who drinks too much because he cannot face a motherless world or a child who brags or lies and cheats to wrest revenge for some huge indignity gnawing at his heart.

The first act of aggression recorded in the western world was the slaying of one brother by another; and today the drug problems, the increasing crime rates and the frequent senseless acts of terrorism, appear simply to perpetuate such a deed on a more universal scale. Rapid transportation, modern technology and communications, all making the world smaller, should bind all people into brotherhood. Human beings are tied together by ideas, ideals and feelings; yet when individuals and nations are motivated by fear and hate, the closer together they live, the more fiercely they hate.

The only force for peace lies in the hearts and minds of people who love and reason, realistically translating

this into the behavior of their governments. It is easy to be cynical about defects in human nature, but deep in every personality is the yearning for goodness, truth, and beauty. Evil, by its own nature, separates itself, not only from the good but from other evil as well. Thieves, with neither enduring loyalty one to another nor basic trust, fall out with one another, for it is the essence of their character. Evil containing the seeds of its own destruction cannot survive and flourish, as the same instinct that drives a man into wickedness drives him to dominate and destroy his associates.

Peace is possible and justice no longer a mockery only when power is put where it belongs — in the hands of men and women who cherish wisdom and righteousness. A solution must be big enough to include everybody, powerful enough to change everybody, and fundamental enough to satisfy the longings for food, work and hope that gnaws at the hearts of millions of people in the underdeveloped nations. Learning that the enemy within us is that which makes our differences seem more important than our similarities, we must teach all people to unite against our real and common enemies: flood and famine, disease and decay, inequality and injustice.

The message of Christmas, having its moral roots in the practicality of Judaism, is designed not so much to change the way men and women think or believe but rather to change the way they act, for while it is easy to believe and admire the truths of the brotherhood of man, it is so very, very hard daily to practice these truths. Intense self-scrutiny and a relentless honesty about one's motives is required as well as daily practicing the art of "loving one's neighbor as oneself." For with the common hope today of remaining alive on this terrestrial globe as neighbors and friends, we must work hard in developing other common interests, such as feeding the hungry, developing jobs for the unemployed, curing the ill and comforting those who are oppressed, enslaved and disheartened.

*Clyde M. Collins, M.D.
Associate Editor
Jacksonville*

Wounded Healers

"Luke, the beloved physician, and Demas greet you," St. Paul wrote to the Church at Colossus nearly two thousand years ago. That Luke was indeed the "beloved physician" of the dynamic Apostle is proved by the little known Monarchian prologue to Luke's own Gospel dated about 200 A.D. It reads: "*Luke, by nation a Syrian of Antioch, a disciple of the Apostles, was afterward a follower of Paul until his martyrdom.*"

That Luke of Antioch was more than just a physician is proved by his authorship of the Gospel that bears his name, as well as the stirring and inspiring account of the Early Church in the Acts of the Apostles. And since in his own Gospel, Luke wrote the beautiful story of the Nativity which is read and portrayed on every form of media at Christmas time, it is fitting to seek to discover what meaning the life and writings of this physician of early Antioch can have for our profession today, some nineteen hundred years later.

How many physicians would possibly be termed "beloved" by their patients? And how many could fill the shoes of the doctor sitting at the bedside of the sick child in the famous painting that epitomizes, more than any other, the ideals — as well as the trials — of the medical profession?

True, the rapid development of the technical side of medicine often relegates the physician, formerly its central figure, to the lowly position of interpreter of laboratory reports. In recent years, too, hospital protocol has often usurped his former task of arbiter of treatment to Doctors of Clinical Pharmacy. They, in turn, tell him what drugs are indicated for what organisms and which compounds fight each other in the body, often admittedly causing more havoc than the disease they are supposed to combat.

How then can a mere human, overworked and harried by the urge to keep up with both science and paperwork, compare in the eyes and affections of patients with a machine called a "CAT scanner" whose giant eye can penetrate and disclose the body's innermost secrets; or with an even more penetrating machine called the "PET scanner" that reveals those secrets in color?

Ultra-scientific medicine is unquestionably a boon in treating disease and combatting death. But what has this development meant to physicians who are supposed to be in complete control of the diagnostic machines and the involved treatment techniques they use?

A flood of articles in current medical and lay publications seem to indicate that the "beloved physician" of even a half century ago — when this writer received his

M.D. from Johns Hopkins — has now declined steadily as the authoritarian figure he once was in the eyes and emotions of his patients. Moreover, today's doctors often suffer badly in the weakest spot of the human personality, their estimation of themselves and their importance in their private world of medicine.

Is the practice of medicine today then to be considered a dangerous profession? Does it leave in fact a trail of "wounded healers" in its wake? The answer from every viewpoint seems to be a resounding YES.

An overstatement? An exaggeration? If so, how explain the fact that one out of seven doctors today is addicted — to alcohol, narcotics, amphetamines, or all three? Explain an addiction rate among doctors one hundred times higher than in the general population and a suicide rate, particularly among young hospital residents, three times the national average. Explain, too, the stated admission by 26% of medical school seniors at one institution recently that use of drugs was a significant concern in their lives, and a crutch in times of stress.

The excuses given for this parlous state of physician impairment are many. Overwork, competition — growing greater all the while as the physician-to-population ratio steadily increases — and the mad scramble to stay ahead of robot machines takes its toll upon both body and mind. An additional factor causing increasing concern among students of medical philosophy is the decline in physician-patient confidence, so obvious in the sharp rise in malpractice suits, the surge of "second opinion" requests, and the rise of medical horror stories upon the nation's bookshelves.

Perhaps even more important, the ability of medical science today to increase the number of people living past the biblical "three score and ten" has created a flood of potential patients with incurable diseases associated with longevity, diseases which the profession that has kept them living so long is unable to cure. It is not happenstance that the highest incidence of physician "impairment" (perhaps better titled "burnout"), occurs among psychiatrists, neurosurgeons and oncologists whose "cure" rates are the lowest in medical practice.

Nor is it difficult to understand how the change from the "beloved" status of the old family doctor to the almost inevitably impersonal scientist of today could eventually wreak a devastating effect upon idealistic young men and women. Embarking upon what they see — in their youth — as a career of service, they eventually face bitter disillusionment. No doubt, the inevitable lowering of the physician's status and stature *vis a vis* his patients has

become a vicious cycle that is inevitably taking an increasing toll upon both the medical *psyche* and the medical *soma*.

Perhaps the "Beloved Physician" who accompanied St. Paul and treated his many ailments was actually much better off nearly two thousand years ago than the doctors of today. He had time to write, besides treating his important patient, thus being able to create his Gospel and the inspiring Acts of the Apostles. As a close companion of Paul — and writer-in-residence, so to speak — Luke may even have contributed something to the preparation of the immortal Epistles, describing the relationship that should exist between man and his God. This very relationship is all too often lost these days by the young physician in his unrelenting pursuit of professional

and therefore financial, success. Certainly through being loved by his famous patient, Luke of Antioch could tap a source of personal strength and self respect denied more and more to physicians of today.

Perhaps through Luke's own example, physicians of today may learn to care more "about as well as for patients" — in the words of a young doctor writing recently in the AMA News. Thus they may, hopefully, be able to escape the spectre of "burnout" that haunts so many doctors today and is of such growing concern to all interested in our profession.

Frank G. Slaughter, M.D.
Jacksonville

Editor's note: With 60 published books in 21 countries and sales of more than 70 million copies, Dr. Slaughter is one of the most widely published physician-novelists in the world today. His most recent book is *Doctor's Daughters*, and he is now working on a novel about "impaired physicians" for publication by Doubleday in the Spring of 1983.

The First Domino to Fall

During the 1981 Legislative Session in Tallahassee this past spring, a group of aggressive non-physicians nearly succeeded in being legislated into physician status. The optometrists of Florida mounted an intensive campaign to get legislation passed that would allow them to prescribe and use "topical drugs and *all light frequencies*" to treat diseases of the anterior segment of the eye.

How did a technical group suddenly acquire enough expertise to diagnose and treat human disease? This becomes an even more intriguing question as all thirteen states that have optometry schools have no provision allowing optometrists to administer or prescribe drugs.

Listening closely in the House and Senate galleries were several other para-professional groups, including chiropractors, naturopaths, mid-wives, nurse practitioners and physician's assistants. If the optometrists are elected to physician status by legislative fiat rather

than academic attainment, guess who will want to be next? *Will ophthalmologists be the first domino to fall?*

All physicians in Florida must be made aware of the potential danger to the people of Florida from legislation of this sort. May we, therefore, request all physicians and other interested parties to contact their senators and representatives and urge them to protect the people of Florida from untrained persons that yearn to "doctor" without any medical training. Weekend lectures and seminars cannot replace the medical doctor's years of formal schooling, post-graduate training, and practice experience.

William H. Houston, M.D.
Vice President
Florida Society of Ophthalmology
Jacksonville

Needs for a School of Public Health In the State of Florida

In 1980, the Florida Advisory Council on Intergovernmental Relations published a report entitled "Strengthening the Partnership for Public Health in Florida." In this report, they recommended that the "Legislature should study the feasibility of establishing a School of Public Health in one of the state universities." It also stated "A School of Public Health in Florida would develop a pool of manpower resources to draw from for recruitment purposes. It could also serve as a continuing education program for public health professionals to continually upgrade their skills and knowledge."

The problem of recruitment of qualified public health professionals with a Masters in Public Health degree and specialization in Public Health or General Preventive Medicine is evident by the difficulties that the Department of Health and Rehabilitative Services (HRS) has had in the placement of such professionals. One of the reasons for this difficulty lies in the fact that the closest schools of public health are in North and South Carolina, Louisiana and Alabama.

A further assessment of the problem is depicted by the fact that out of 42 County Health Officers' positions filled, less than 50 percent have had formal public health training. The situation is no different in regard to county health nurses, nutritionists, sanitarians and other public health supervisors. To compound the problem, it is expected that within five years, there will be 15 to 20 physician vacancies in health departments and 20 to 30 vacancies in supervisory nursing and environmental health positions. The problem of recruitment and retaining of qualified health professionals is a concern of the university system, the Governor, the Legislature and the Department of HRS.

In order to address the need of a graduate program in public health, a number of efforts have been taken throughout the state resulting in the teaching of core courses at several of our state universities. A full-fledged masters degree program will have as its objective the education of health professionals to meet the needs in our community. It will also educate consumers on improving and maintaining personal health and how to best utilize the existing health delivery systems. The School of Public Health can also conduct research in epidemiology, health behavior, health planning and the control of environmental factors affecting health.

Existing expertise of the State University system in its Colleges of Health, Environmental Engineering, Biological Sciences, Behavioral Sciences and Business provides a solid basis for the development of a Masters Degree in Public Health. An M.P.H. program would serve as a focal point for a network of public health educational and service activities throughout the state, in cooperation with other health facilities such as County Health Departments, hospitals, Health Maintenance Organizations, volunteer health organizations, etc.

A School of Public Health in the State of Florida not only will address the needs of the State, but to some degree will also address regional, national and international needs. If the State of Florida is to deliver public health services in an effective and efficient fashion, we need to look at the development of such a school of public health as one of the ways to keep pace with the growth in Florida and with our image as a progressive state which addresses its own problems with a sense of commitment and independence.

*Jorge Deju, M.D., M.P.H.
Director
Department of Health and Human Services
Seminole County Health Department
Sanford*



PAIN AND TENSION...

Double fault for weekend warriors

ACE THE ACHE
with

Equagesic[®]™

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use

of minor tranquilizers (meprobamate, chloridiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug. Meprobamate passes the placental barrier. It is present both in umbilical-cord blood and in near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery. Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow CNS stimulants, e.g. caffeine, Metrazol or amphetamine,

may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported; most of these returned to normal without discontinuation of the drug. Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdose with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright © 1981, Wyeth Laboratories
All rights reserved.

* This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, PA 19101





Down with pain

Step up to reliable relief

for mild to moderate pain

Wygesic[®]

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see Warnings). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill, however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis and myocardialopathy, have also been reported. Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine, and levallorphan are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting and drowsiness. Appropriate literature should be consulted for further information (JAMA 237:2406-2407, 1977). Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

Copyright © 1981, Wyeth Laboratories.
All rights reserved.

Wyeth Laboratories
Philadelphia, PA 19101



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

December 1981
Vol. 68 • No. 12

Nongonococcal Urethritis A Clinical Problem of the 80's

Pierre J. Bouis Jr., M.D., Anthony M. Messina, M.D. and Mitchel Hoffman, M.D.

Abstract: The past few years have witnessed development of a new sexually transmitted disease, nongonococcal urethritis (NGU). Differentiation of this entity from gonococcal urethritis (GCU) depends upon the isolation of *Neisseria gonorrhoeae*. Nongonococcal urethritis is now considered the most common sexually transmitted disease in men, with an extensive counterpart syndrome in women.

Conflicting reports exist as to whether NGU occurs more frequently in the higher or lower socioeconomic classes; however, many researchers believe that the lower socioeconomic classes are at greater risk of exposure to NGU and its complications. The upper socioeconomic classes have less gonorrhea and, therefore, the cases of NGU appear at a relatively higher rate by comparison.

Knowledge concerning the etiology, nature and complications of NGU is rapidly expanding.

NGU has several suspected etiologies but there is clinical evidence that only two microorganisms, *Chlamydia trachomatis* and mycoplasma (*Ureaplasma urealyticum*, T-strain mycoplasma), play an important etiologic role.^{1,2} However, in many cases the causative agent is not isolated and the etiology remains unknown.³

Various studies report that 40-50% of cases are caused by *Chlamydia trachomatis* (obligate intracellular organisms).^{3,4} The etiologic significance of mycoplasma is less well established.⁵ Mycoplasma organisms have

been implicated in up to 25% of the cases of NGU.⁶ Effectiveness of specific treatment, i.e. spectinomycin, when mycoplasma has been the sole isolate lends support to its role as an etiologic agent.

A smaller percentage of cases in males may be caused by other organisms such as *Candida albicans*, *Herpesvirus hominis* and *Trichomonas vaginalis*.

Clinical Course

The incubation period for NGU in males is one to three weeks but may be longer.⁷ Asymptomatic infections may account for up to one fifth of cases.⁶ Symptomatic patients usually have dysuria, urinary frequency and urethral discharge of varying severity. The discharge is usually thin and mucoid but may be purulent. Hematuria and epididymitis (usually unilateral) occasionally occur. Compared to GCU, the incubation period is longer but the dysuria is milder and the discharge tends to be less. However, NGU may occur concomitantly with GCU. This is often "diagnosed" as postgonococcal urethritis which presents as persistence of a mild urethritis with the discharge changing from purulent to mucoid after treatment.

The Authors

PIERRE J. BOUIS JR., M.D.

Dr. Bouis is a practicing obstetrician/gynecologist in Cocoa Beach.

ANTHONY M. MESSINA, M.D.

Dr. Messina is an Associate Professor with the Department of Obstetrics and Gynecology at the University of South Florida College of Medicine.

MITCHEL HOFFMAN, M.D.

Dr. Hoffman is a medical resident with the Department of Obstetrics and Gynecology at the University of South Florida College of Medicine.

The female partners of symptomatic males are usually asymptomatic. The incubation period in females is frequently several weeks in length.⁷ Dysuria along with physical evidence of urethral inflammation does occasionally occur but the counterpart syndrome in women more often includes chronic cervicitis with hypertrophic cervical erosions and a mucopurulent endocervical discharge. This clinical picture is similar to that sometimes produced by *Neisseria gonorrhoeae* infection.³

Complications

Proctitis may develop in both males and females through exposure by anal intercourse. Epididymitis and prostatitis develop as a complication of urethral colonization and/or recurrent infection. Reiter's syndrome has also been associated with primary NGU infection.^{2,6} Reiter, a German physician, recognized a syndrome in male homosexuals infected with Chlamydia. This syndrome was manifested by the onset of diarrhea followed by development of urethritis, conjunctivitis and polyarthrititis.⁸ Ninety percent of males with Reiter's syndrome carry the HLA-B27 antigen (a single compatibility antigen) which suggests a genetic predisposition to the disease.¹

The most serious complication in women is acute salpingitis. Various studies have implicated Chlamydia trachomatis as accounting for 10-20% of pelvic infection cases.⁹ Mycoplasma may account for a smaller number of salpingitis cases.¹⁰ Because of the extensive reproductive tract involvement, NGU may be responsible for male and female infertility.

Approximately one third to one half of infants exposed to chlamydial infection in the vaginal canal during birth develop inclusion conjunctivitis. This is a common form of conjunctivitis in infants and is mucopurulent in nature. The most serious complication is a characteristic pneumonia syndrome which develops two weeks to four months after birth in approximately 10-20% of exposed infants.⁹ Mycoplasma has been implicated in both pregnancy wastage and low birth weight infants, but a definite cause and effect relationship has yet to be established.¹⁰

Adult chlamydial eye infections are acquired primarily through oral-genital sex when the eye comes in contact with infected secretions. Onset is nonacute with an incubation period of 2-19 days, with conjunctival hyperemia followed by follicular hypertrophy and a mucopurulent exudate. The infection is frequently confused with an adenoviral conjunctivitis.

Diagnosis

Laboratory facilities for the isolation of Chlamydia trachomatis and mycoplasma are not widely available and the diagnosis is, therefore, often based on clinical findings and the exclusion of gonorrheal infection.

The isolation of Chlamydia requires access to a virology laboratory. The State of Florida provides services for Chlamydia culture; however, the results usually take from four to six weeks to be obtained. Specimens sent for culture should include urethral discharge fluid, endocervical and cervical scrapings, prostatic massage secretions (prostatitis), rectal swab (proctitis) and conjunctival scrapings. Mycoplasma can be cultured in brain-heart infusion broth but again this is not widely available.

Gram stains usually show neutrophils without intracellular gram negative diplococci. Conjunctival scrapings may show intracytoplasmic inclusion bodies with Giemsa stain, thus the phrase "inclusion conjunctivitis." Generally, however, cytologic methods for diagnosing chlamydial infection are not successful because of limited sensitivity.^{7,9}

Because of the very high background prevalence of antichlamydial antibodies, the usefulness of serology is limited to systemic complications where much higher antibody levels occur. Serology is applicable to the differentiation of epididymitis versus urethritis, salpingitis versus cervicitis, and pneumonia versus conjunctivitis in the infant. Effective serological tests for antibodies to mycoplasma are still in the developmental stage.

A microimmunofluorescence test for Chlamydia seems to be a promising diagnostic test for the near future.⁹

Treatment

Urethritis and cervicitis are frequently managed by first excluding *Neisseria gonorrhoeae* infection and then treating the patient with oral tetracycline. Tetracycline provides excellent coverage for both Chlamydia trachomatis and mycoplasma organisms. Erythromycin would be the drug of choice in tetracycline sensitive individuals and pregnant patients.

Sulfonamides are active against Chlamydia trachomatis but not against mycoplasma. Spectinomycin would be a better drug to use in the following: resistant cases, cases where Chlamydia trachomatis cannot be isolated, or cases where mycoplasma is the sole isolate.¹

Chlamydial inclusion conjunctivitis in the newborn is treated with sulfacetamide ointment for 14 days. Treatment with oral sulfasoxazole or erythromycin for 7-14 days may also be necessary to minimize the risk of recurrent disease or subsequent pneumonia. Recommended treatment for chlamydial pneumonia is erythromycin 40 mg/kg in divided doses for 14 days.⁴

Chlamydial inclusion conjunctivitis in the adult should be treated with a three-week course of oral tetracycline, preferably 2 grams per day. Adult conjunctivitis does not respond well to topical antibiotics.

Because of the risk of developing salpingitis, female patients who continue to have symptoms should be treated with a prolonged course of tetracycline or placed on doxycycline (Vibramycin) therapy.

Relapses are common, although many recurrences may actually be reinfections. It is important to treat the sexual partners even if they are asymptomatic at the same time the patient is treated. This will keep the reinfection rate low and hopefully prevent the serious complications of salpingitis in the female partner.

Conclusion

It is apparent that further elucidation of the etiology of NGU and improvement in the diagnostic techniques of the known etiologies of this disease are needed before

effective control measures can be instituted. Adequate methods are available for research, but the goal must be to have diagnostic methods available in the routine bacteriology laboratory.

Chlamydia trachomatis is a common cause of neonatal conjunctivitis and because silver nitrate is ineffective as a prophylaxis, perhaps a new treatment regimen will be forthcoming.⁹

Recently a wealth of new information has surfaced about NGU. Although much information is yet to be known, many answers are likely to be obtained in the near future as interest increases in what many epidemiologists are calling the "sexually transmitted disease of the 80's."

References

1. Bowie, W.R. and Holmes, K.K.: *Infectious Disease, A Modern Treatise of Infectious Processes*, P. Hoeprich, edit. Ch. 52:486-490, 1977.
 2. Bowie, W.R. and Holmes, K.K.: *Cl. Micro. Newsletter*. Vol. 2, No. 9:1-4, 1980.
 3. Hjorth, N., et al: *Venereology in Practice*. Year Book Medical Publishers, Inc., 1976.
 4. Eisenberg, M.S., et al: *Manual of Antimicrobial Therapy and Infectious Diseases*. W.B. Saunders Co., 1980.
 5. Schofield, C.B.S.: *Sexually Transmitted Diseases*. Churchill Livingstone, 3rd Edition, 1979.
 6. Feldman, Y.M. and Nikits, J.A.: *Sexual Medicine Today*. Vol. 4, No. 3:8-14, 1980.
 7. Hirschmann, J.V.: *Infectious Disease Manual*. Sec. 3:299-309, 1976.
 8. Schacter, J.: *Medical Progress: Chlamydial Infections, Part II*. N. Eng. J. Med. 298:490-495, 1978.
 9. Sweet, R.L. and Schocter, J.: *New Horizons in Obstetrics and Gynecology*, Vol. 1, No. 1:3-8, 1980.
 10. Eschenbach, D.A.: *Infections in Obstetrics and Gynecology*. No. 6:9-12, 1980.
- Dr. Bouis, 1980 North Atlantic Avenue, Suite 325, Cocoa Beach 32931.

Spinal Cord Injury in South Florida

Newton C. McCollough III, M.D.; Barth A. Green, M.D.;
K. John Klose, Ph.D.; Myron L. Goldberg, Ph.D. and Caryl Klose, R.N.

Abstract: This paper describes the spinal cord injury population served by the South Florida Regional Spinal Cord Injury System (SFRSCIS) from January 1979 through March 1981. The data presented is based on 114 patients. Comparisons are presented which show the similarities and differences between the SFRSCIS patient population and data reported by the National Spinal Cord Injury Data Center in Phoenix, Arizona. The most outstanding difference is found in the injury etiology categories. Over forty percent of the South Florida injuries were a result of penetrating wounds while only twelve percent of those reported nationally were attributed to this cause. Nationally, vehicular accidents account for nearly fifty percent of the injuries. Only twenty-eight percent of the South Florida injuries were the result of vehicular accidents. In addition to the comparisons, data is presented on the relationship between severity of injury and number of days of initial hospitalization.

It has been estimated that there are a quarter million spinal cord injury victims living in the United States. Approximately 10,000 new traumatic injuries occur each year in this nation. In Florida, the State Spinal Cord Injury Council projects 450 new injuries per year based on the resident population and yearly influx of tourists.

Although the impact of spinal cord injury is devastating in terms of cost and emotional impact to the

individual and society, the incidence to population ratio is small. Spinal cord injury differs from other diseases and traumatic injuries in that multiple organ systems are affected. Depending on level and severity of injury, trauma can affect any or all of at least seven organ systems. The pathophysiological problems most commonly associated with spinal cord injury include compromising of the following organ systems: cardiovascular, gastrointestinal, genitourinary, musculo-skeletal, nervous system, respiratory and skin. These complications may present with the injury or develop post-injury as sequelae.

The University of Miami/Jackson Memorial Medical Center has been designated by both the State of Florida and the Rehabilitation Services Administration (RSA) of the United States Department of Education as a Spinal Cord Injury Center. The South Florida Regional Spinal Cord Injury System (University of Miami/Jackson Memorial Medical Center) is one of fourteen (14) nationally designated Centers which are engaged in a national cooperative program of spinal cord injury service and data collection.

In order to qualify for RSA designation as a Model System, specific components are required. The following range of services are needed to meet minimum criteria:

1. **Emergency Services and Acute Care:** Evacuation and transportation; emergency and early acute care (1-10 days post onset).

The Authors

NEWTON C. MCCOLLOUGH, III, M.D.

*Dr. McCollough is Professor and Chairman
Department of Orthopaedics and Rehabilitation at University of Miami
and Co-Director, South Florida Regional Spinal Cord Injury System.*

BARTH A. GREEN, M.D.

*Dr. Green is Associate Professor, Department of Neurological
Surgery, University of Miami and Co-Director, South Florida Regional
Spinal Cord Injury System.*

K. JOHN KLOSE, Ph.D.

*Dr. Klose is Associate Professor, Department of Neurological Surgery,
University of Miami, and Project Coordinator, South Florida Regional
Spinal Cord Injury System.*

MYRON L. GOLDBERG, Ph.D.

*Dr. Goldberg is Research Associate, Department of Neurological
Surgery, University of Miami, and Data Systems Director, South
Florida Regional Spinal Cord Injury System.*

CARYL KLOSE, R.N.

*Ms. Klose is Research Nurse Clinician, Department of Orthopaedics
and Rehabilitation, University of Miami, and Data Collector, South
Florida Regional Spinal Cord Injury System.*

2. **Rehabilitation Services:** Physical restoration (10-120 days post onset), vocational, educational preparation (should be initiated during care); community placement and adjustment.

3. **Long Term Comprehensive Follow-Up:** Medical, social, psychological, and vocational follow-up on a regularly scheduled basis.

Dade County, the major population center within the catchment area, is serviced by Rescue Divisions of five Fire-Rescue Departments, all providing advanced life support meeting or exceeding the existing national criteria. Within the remainder of the catchment area, pre-hospital emergency care is a mix of advanced or basic life support dependent upon individual communities' capabilities and needs.

The South Florida Regional Spinal Cord Injury System (SFRSCIS) is staffed by a full time Emergency Medical Services (EMS) Administrator who serves as liaison between the Center and the EMS community. Once a patient is admitted or transferred to the SFRSCIS in the acute phase, care is provided in the new ten bed Neurosurgical Intensive Care Unit of Jackson Memorial Hospital which is staffed by Neurosurgeons and a full-time Intensivist. All patients are continuously computer monitored. Consults from all medical specialties are available on a 24 hour basis.

The recently constructed and renovated Jackson Memorial Hospital/University of Miami Rehabilitation Center is located immediately adjacent to the Acute Care Unit. Within this 100 bed comprehensive rehabilitation center, 50 beds have been designated for spinal cord injury patients. The multi-disciplinary rehabilitation team begins its involvement within the first 24 hours following injury and establishes what usually develops into a lifelong relationship with each patient and his or her family. This phase of system care emphasizes not only physical rehabilitation, but encompasses psychosocial, educational, sexual, recreational and vocational rehabilitation as well.

The rehabilitation staff is composed of physicians, nurses, therapists and counselors. Therapists include: Physical Therapists, Occupational Therapists, Recreational Therapists, Educational Therapists, Speech Therapists, Respiratory Therapists, Dieticians and Prosthetic-Orthotics Technicians. Counselors are: Social Service, Vocational Rehabilitation, Work Evaluation, Peer Counselors, Sexual Counselors and Psychologists.

Long term patient follow-up is provided by SFRSCIS's conduction of weekly outpatient clinics staffed by the Department of Orthopaedics and Rehabilitation, the Department of Urology, and Allied Health Professionals. Patients come to the clinic for regular check-ups, supplies, and for splint problems.

Data Presentation

One of the functions of a Regional Spinal Cord Injury System is the collection of data concerning patients' personal information (e.g., sex, age, ethnicity) and cost aspects of their acute, rehabilitation, and follow-up care. Each of the fourteen systems submit this information to the National Data Center located in Phoenix, Arizona for compilation of figures on spinal cord injury. The data presented in this paper covers the first 27 months of SFRSCIS participation in the National Model Systems Program. Along with comparisons between national statistics and those of SFRSCIS, a review of the cost and other rehabilitation data specific to SFRSCIS is provided.

Comparison of SFRSCIS data to that of the combined data of the other thirteen Model Systems reveals some similarities, yet interesting discrepancies. Breakdowns of SCI patients by sex, ethnicity/race, and age group are presented in Tables 1, 2, and 3, respectively. As evident in Table 1, the proportion of males and females within SFRSCIS is similar to those reported by the National Data Center. However, a noticeable difference in distributions associated with the ethnicity-/race variable may be observed in Table 2. As compared to national data, the proportion of SFRSCIS spinal cord injured with an Hispanic origin is relatively high. This difference would be expected in view of the extremely high concentration of Cuban-Americans within the general population of South Florida. This discrepancy will likely increase in the future, due to the recent influx of over 100,000 new Cuban refugees.

Table 1

Comparison of SFRSCIS and National Distributions of SCI by Sex				
SEX	SFRSCIS		National	
	#	%	#	%
Male	90	78.9	3505	81.6
Female	24	21.1	790	18.4
TOTAL	114	100.0	4295	100.0

Table 2

Comparison of SFRSCIS and National Distribution of SCI by Ethnic/Race Categories				
Ethnic/Race	SFRSCIS		National	
	#	%	#	%
Non-Hispanic White	53	46.5	3334	77.6
Non-Hispanic Black	33	28.9	582	13.5
Hispanic Origin	27	23.7	236	5.5
American Indian	0	0.0	95	2.2
Other	1	.9	48	1.1
TOTAL	114	100.0	4295	100.0

Table 3 reveals a noticeable difference between SFRSCIS and national distributions of injury incidence across age groups. Differences exist at both the upper and lower limits of the age categories. The proportion of victims over 50 years of age is twice that of the national statistics for the SFRSCIS.

Over 80 percent of the injuries reported by the National Data Center were incurred by individuals under the age of 40. In comparison, patients 40 years of age or younger, comprised a somewhat lower proportion (74.6%) of the total number of patients within the SFRSCIS data bank. In particular, the difference occurs in the 50 and over age group; over 17 percent of the injuries in SFRSCIS occurred in this age group, while only 10.4 percent of the injuries reported by the National Data Center were in this eldest age group. This difference is likely attributable to the fact that South Florida embodies a comparatively high population of retired, and therefore elderly, citizens. However, it is instructive to note (from the standpoint of prevention) that well over half (58.8%) of the injuries within SFRSCIS were received by individuals between the ages of 10 and 29.

Injury Etiology—A comparison between categories of injury etiology documented by SFRSCIS and the National Data Center is illustrated in Figure 1. As can be clearly seen in this figure, the proportions associated with SFRSCIS and the National Data Center for several etiology categories differ substantially; the most notable

Table 3

Comparison of SFRSCIS and National Distributions of SCI by Age Groups						
Age Group	SFRSCIS			National		
	#	%	CUM %	#	%	CUM%
0- 9 Years	1	.9	.9	53	1.2	.2
10- 19 Years	21	18.4	19.3	1184	27.6	28.8
20- 29 Years	46	40.4	59.6	1603	37.3	66.1
30- 39 Years	17	14.9	74.6	640	14.9	81.0
40- 49 Years	9	7.9	82.5	367	8.6	89.6
50 And Over	20	17.5	100.0	448	10.4	100.0

differences existing in the area of penetrating wounds. With respect to the National Data Base, penetrating wounds accounted for only 12.5 percent of all reported injuries. In comparison, over 40 percent of SFRSCIS injuries were attributable to penetrating wounds. One plausible, yet speculative, explanation for this striking difference may be found in the fact that areas of South Florida (particularly in Dade County), have high density, urban populations which are associated with a relatively high rate of violent crimes involving the use of hand guns. The extent to which penetrating wounds account for such a large proportion of spinal cord injuries will be continually assessed in the coming years.

Within SFRSCIS, comparison of etiology by ethnicity/race reveals that the injuries incurred by Non-Hispanic whites most frequently (32.1%) were caused by a vehicular accident. In striking contrast, a penetrating wound was the most frequent (60.6%) etiology on Non-Hispanic black injuries.

Table 4

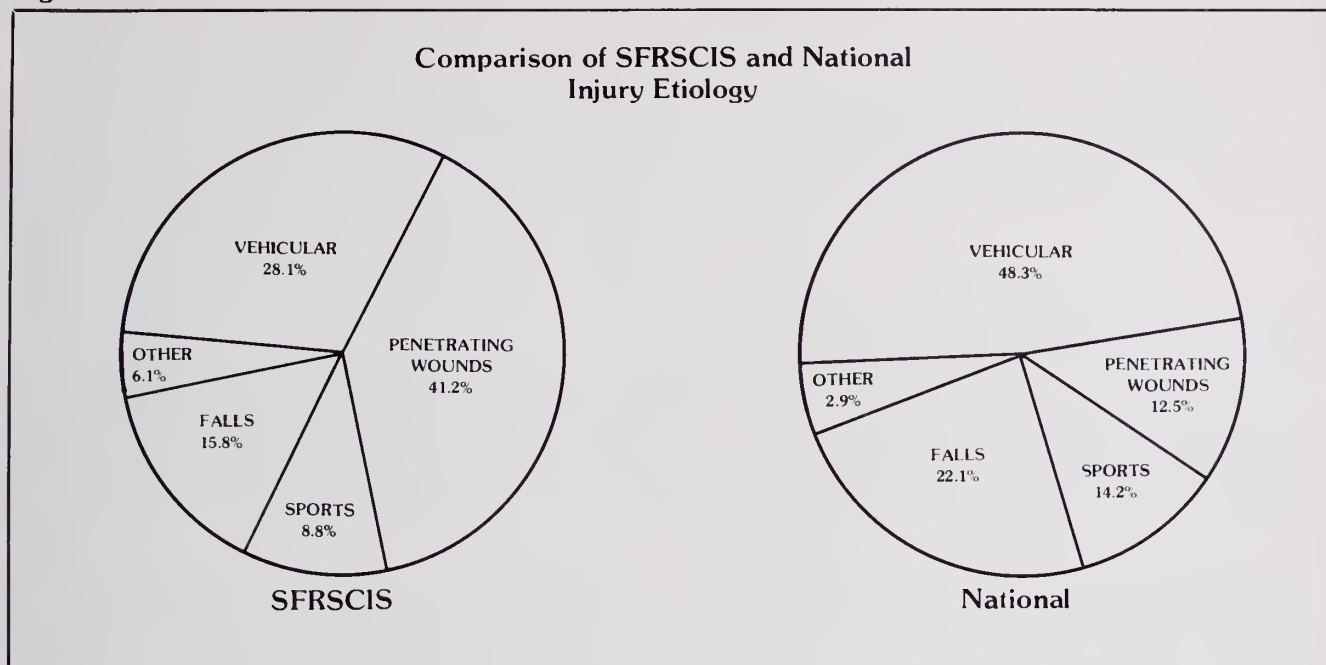
Distribution of SFRSCIS Patients by Age Group and Injury Etiology							
INJURY ETIOLOGY	Age Group						
	10-19 Years	20-29 Years	30-39 Years	40-49 Years	50 and over	Total	
	# % ^a	# % ^a	# % ^a	# % ^a	# % ^a	# % ^b	
Vehicular Accident	8 38.1	15 32.6	3 17.6	2 22.2	4 20.0	32 28.3	
Penetrating Wound	6 28.6	20 43.5	8 47.1	4 44.4	9 45.0	47 41.6	
Falls	2 9.5	5 10.9	4 23.5	2 22.2	5 25.0	18 15.9	
Sports	4 19.0	4 8.7	2 11.8	0 0.0	0 0.0	10 8.9	
Other	1 4.8	2 4.3	0 0.0	1 11.1	2 10.0	6 5.3	

^a column percent

^b injury etiology for the one patient in the 0-9 age group was omitted from this table.

Table 4 presents injury etiology by age group. It is important to note that injuries occurring to patients under 20 years of age most often resulted from vehicular accidents. On the other hand, penetrating wounds were most frequently the cause of injuries within each age category above the age of 20.

Figure 1



Change in Life Styles of SFRSCIS Patients —

The extent to which life styles, reflected in place of residence and living companion, is altered following spinal cord injury is presented in Tables 5 and 6. (It should be noted that at the time these tables were generated, 87 of the 114 SFRSCIS patients had been discharged from their hospitalization).

As can be seen in Table 5, the distributions of place of residency at injury onset and at discharge did not differ in any substantial manner. At each measurement period, private residence was most often indicated. However, in Table 6, it is interesting to observe a slight, yet noticeable,

difference in the distributions associated with living companion at injury onset and at discharge.

This difference in living companion may be attributable to the fact that family members were chosen as living companions to a greater degree at discharge than at the time of injury. Given the need for a highly supportive living system immediately following discharge, this shift in living companion from injury onset to discharge is entirely understandable. As the number of patients who are followed by our staff beyond discharge increases, trends in both place of residence and living companion will be examined across more extended periods of time.

Table 5

Place of Residence at Injury Onset, Rehabilitation, Discharge and 1-Year Follow-up ¹						
Residence Classification	Onset		Rehab Discharge		1-Year Follow-up	
	#	% ^a	#	% ^a	#	% ^a
Private Residence	79	90.8	77	88.5	52	91.2
Hospital	2	2.3	2	2.3	2	3.5
Group	1	1.1	3	3.4	0	0.0
Nursing Home	0	0.0	4	4.6	3	3.4
Other	5	5.7	1	1.1	0	0.0
TOTAL	87	100.0	87	100.0	57	100.0

^a column percent

¹ table includes only those patients who completed their initial hospitalization and did not expire.

Table 6

Living Companion at Injury Onset, Rehabilitation Discharge and 1-Year Follow-up						
Living Companion	Onset		Rehab Discharge		1-Year Follow-up	
	#	% ^a	#	% ^a	#	% ^a
Family	48	55.2	61	70.1	38	66.7
Friend	20	23.0	10	11.5	11	19.3
Alone	15	17.2	6	6.9	2	3.5
Institution	2	2.3	8	9.2	5	8.8
Other	2	2.2	2	2.2	1	1.8
Total	87	100.0	87	100.0	57	100.0

Table 7

SFRSCIS Statistics For Duration of Initial Hospitalization and Rehabilitation Periods (Injury-to-Discharge) Associated With Neurological Impairment				
		Days from Injury to Center Discharge		
		Median	Mean	Standard Deviation
Paraplegic Incomplete (N=24)		96.5	109.0	67.1
Paraplegic Complete (N=26)		163.5	150.8	45.5
All Paraplegics (N=50)		121.5	130.7	60.1
Quadriplegic Incomplete (N=29)		168.0	155.4	81.1
Quadriplegic Complete (N= 8)		211.5	242.4	81.2
All Quadriplegics (N=37)		179.8	174.2	87.9
TOTAL (N=87)		150.0	149.2	75.3

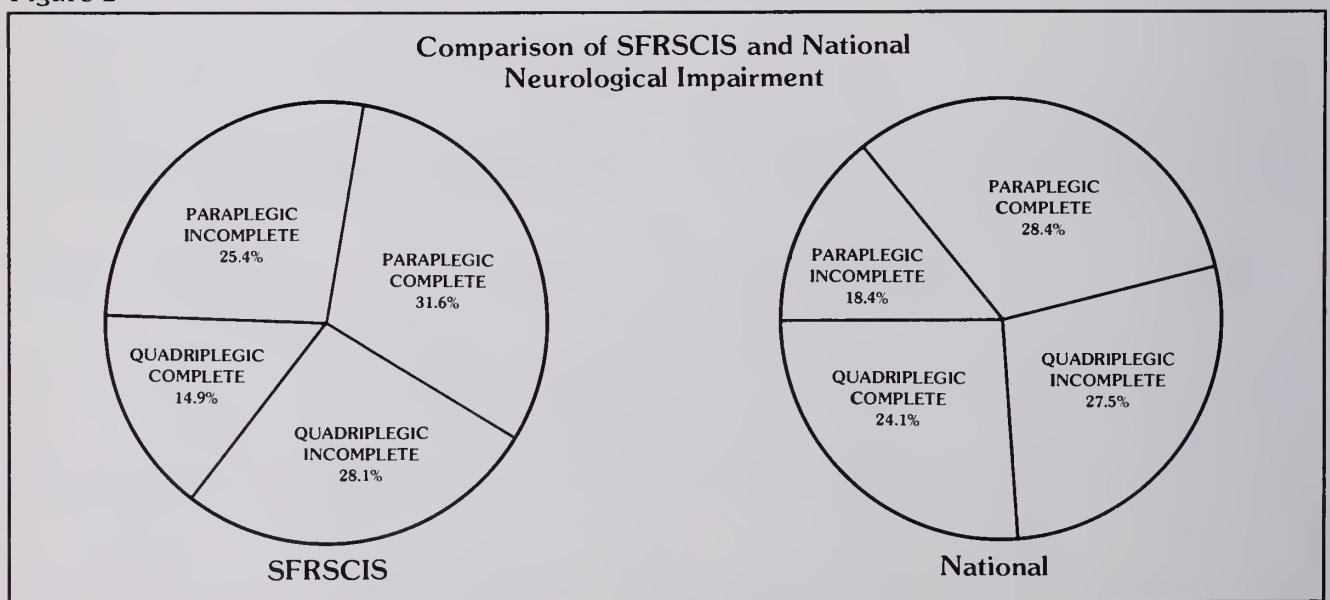
Neurological Impairment — The relative distributions of neurological impairment for SFRSCIS and the National Data Base are provided in Figure 2. In this figure, the single substantial difference between the distributions occurs within the Quadriplegic-Complete category. While 24.1 percent of all injuries reported by the National Data Center were classified as Quadriplegic-Complete, only 14.9 percent of SFRSCIS injuries were diagnosed as such.

The variance in complete versus incomplete quadriplegics between SFRSCIS and the national data may be attributed to two factors: (1) the stress placed upon the training of pre-hospital care personnel in neurological assessment and stabilization of possible SCI victims and (2) the higher percentage of victims sustaining SCI as a result of violence which often results

in incomplete transection of the cord. Additionally, spinal cord injuries resulting from violence normally occur in the thoracic or lumbar regions as opposed to the high incidence of cervical injuries resulting from motor vehicle trauma.

A breakdown of days from injury-to-home (i.e., initial hospitalization) by neurological impairment for SFRSCIS patients is presented in Table 7. As can be seen, quadriplegics, on the average, tended to have a longer initial hospitalization care period than did paraplegics. This overall result for quadriplegics versus paraplegics is very similar to that reported by the National Data Center. It is of some interest to note, however, that the average number of days from injury-to-home for quadriplegics with *incomplete* injuries was approximately equal to that for paraplegics with *complete* injuries.

Figure 2



Summary

This report highlights the similarities and differences between SFRSCIS and the thirteen other federally designated Spinal Cord Injury Model Systems. The data was collected over a 27 month time period. The most striking difference is the proportion of injuries due to penetrating wounds. Penetrating wounds were the major cause of SCI in South Florida in contrast to only twelve percent nationally. Legislators might consider this point when debating the need for hand gun laws.

One of the primary purposes of Model System programs is to determine the efficacy of specialized care centers for the spinal cord injured. The effectiveness of center care will be evaluated on the basis of length of

hospitalization, cost, and vocational status following discharge. At the present time, the patient population is too small to make any valid conclusions based on system/non-system comparisons. This question will be dealt with in following years with adjustments being made for severity of injury and concomitant injury or multiple trauma.

Acknowledgement

This project was supported by a grant from the Department of Education, Division and Procurement Management Division #G008005851 entitled "South Florida Regional Spinal Cord Injury System."

- Dr. McCollough, P.O. Box 016960, University of Miami, Miami 33101.

Blepharospasm

Jonathan D. Trobe, M.D.

Abstract: Blepharospasm, or uncontrollable eyelid closure, occurs in a number of disease states. The most common form is idiopathic (or "essential"), and may represent either a psychosomatic or dystonic disorder, or perhaps both. Insight-oriented psychotherapy has largely failed; behavior modification approaches have had some success in limited trials. Treatment with agents which affect CNS dopaminergic and cholinergic transmission has been disappointing, but recent investigations of anticholinergics are promising.

Selective surgical ablation of seventh nerve branches destined for the upper face remains the most effective treatment. Occasionally troublesome side effects of this procedure limit its indications to the severely disabled.

A 55-year-old man began to have frequent blinking which progressed over a period of several months to intermittent and uncontrollable eyelid closure. The eyelid spasms interrupt most of his waking activities including social conversation, shopping, and driving. At first triggered by emotional tension, the attacks now seem to occur without any precipitants. Whistling or humming or conversation used to relieve the spasms, but he has to pry the lids apart in order to keep them open. (Figs. 1a, b, c).

Among his consultants have been ophthalmologists, neurologists, psychiatrists, neurosurgeons, plastic surgeons, hypnotists, and acupuncturists. None of the treatments have had any lasting benefit.

He is suffering from "essential blepharospasm," a disorder of uncertain etiology which produces a spasmodic contraction of the orbicularis oculi in men and women between the ages of 50 and 70 years. His presentation and clinical course are typical: first comes excessive blinking which may be passed off as a facial tic or sensitivity to light. This leads eventually to incapacitating bilateral blepharospasm, sometimes accompanied by facial grimacing, including lip smacking and tongue protrusion. The only relief occurs during sleep. The general physical, neurological, and ocular examinations are invariably normal.

First described over a century ago, this disease was originally believed to be a manifestation of senescence, hence "senile blepharospasm." It has since been called "functional or psychic blepharospasm" because emotional tension intensifies its expression, because patients with conversion reactions may manifest blepharospasm, and because patients are said to have abundant neurotic symptomatology. Others believe that it represents an early and sometimes isolated manifestation of a spontaneous orofacial dystonia, a neurodegenerative disease believed to affect basal ganglionic structures.

Patients afflicted with excessive eyelid closure usually find their way first to an ophthalmologist who should consider the following differential diagnosis:

Trigeminal irritation, in which blepharospasm is secondary to photophobia and pain; eyelids are usually contracted but not closed and ocular or meningeal inflammatory signs are invariably present.

Difficulty with lid opening. This is not true blepharospasm but a supranuclear deficit or bradykinesia involving upper lid elevation seen in basal ganglia disorders such as Parkinson's disease.¹

Reflex blepharospasm — involuntary eyelid closure upon tactile or photic stimulation, seen in premature infants and in individuals with extensive subcortical disease.^{2,3}

Hemifacial spasm — unilateral spasmodic facial contracture which may follow an old Bell's palsy but is more often cryptogenic. Hyperexcitability of the ipsilateral seventh nerve is believed to be caused by compression of this nerve by an aberrant vessel at its extramedullary intradural course and is often relieved by inserting a sponge between them. Known as the Jannetta procedure, this involves a suboccipital craniectomy.^{4,6}

The Author

JONATHAN D. TROBE, M.D.

Dr. Trobe is an Associate Professor with the Department of Ophthalmology, University of Florida College of Medicine, Gainesville.

Spastic paretic facial contracture. Unilateral persistent facial contracture may follow a healed Bell's palsy. If accompanied by undulating contractions of orbicular oculi and no history of Bell's palsy, one should suspect intrinsic pontine disease, either glioma or multiple sclerosis.^{7,8}

Tonic blepharospasm consists of delayed relaxation of orbicularis oculi after forceful closure and occurs in muscle diseases such as myotonic dystrophy, tetany, hypothyroidism, and hyperkalemic periodic paralysis.⁹

Psychic blepharospasm. Intense and bilateral involuntary eyelid closure may be a hysterical manifestation in young females, usually responding to psychotherapy.¹⁰

Tics or habit spasms consist of brief, patterned predictable episodes usually involving the face. They usually occur in childhood and are rarely sustained enough to cause functional disability and mimic essential blepharospasm.¹⁰ Persistent and evolving facial tics may be the first sign of Gilles de la Tourette's disease, an idiopathic basal ganglia disorder affecting males in the first decade and responding to haloperidol, a dopamine antagonist.¹¹

The many patients who do not fit clearly into any of these categories will be labelled as having "essential" blepharospasm.¹²⁻¹⁴ In the controversy over whether this condition is fundamentally psychopathologic or neuro-pathologic, newer evidence is favoring the latter.

In support of the psychopathologic etiology is the frequent documentation of altered affect,^{15,16} especially depression, and the fact that blepharospasm resembles a facial tic and is sometimes relieved by placebos, tranquilizing medications, psychotherapy,^{10,17} behavior modification,^{18,19} and hypnosis.²⁰ As yet there have been no comprehensive reports of the psychic disturbances in these patients, and results of successful psychotherapy are limited to isolated case reports.

Patients with essential blepharospasm referred in the Ophthalmology Clinic at the University of Florida receive a psychiatric interview as part of a study to help determine if they display characteristics of an endogenous or reactive psychoneurosis.

In collaboration with psychologists, I have tried bio-feedback techniques on two patients suffering from debilitating blepharospasm. Electromyography needles were placed in the orbicularis oculi and contractions produced disturbing noise on an audio channel. The patients learned to reduce the force and frequency of eyelid closure while connected on the sound monitor but relapsed quickly between trials.

The frustratingly low success rate of psychotherapy has reinforced the neuropathologic theory of the origin of blepharospasm. Further support for an "organic" basis for essential blepharospasm comes from the fact that it is often found in association with abnormal facial

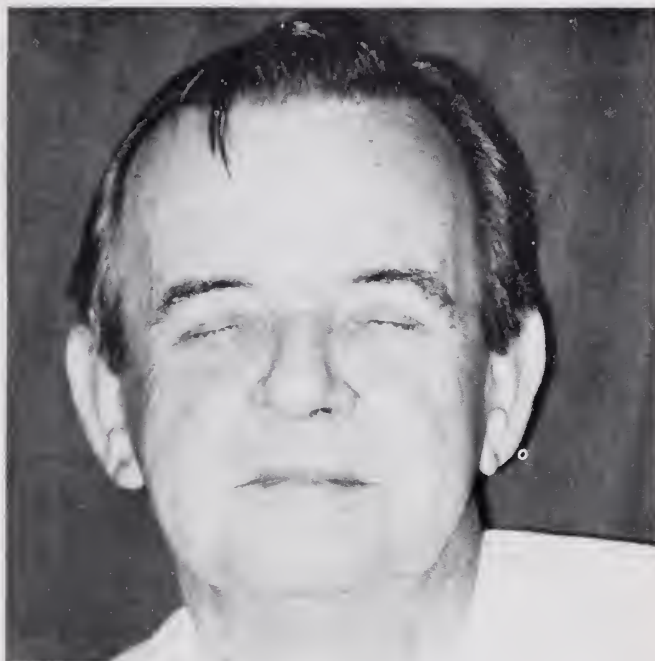
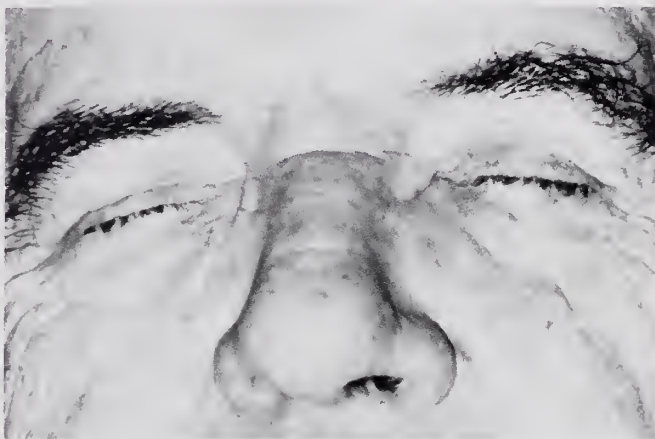


Fig. 1. — Patient with essential blepharospasm manifesting involuntary eyelid closure (a, b). He must pry lids apart to keep them open (c).



and head movements and postures which are similar to those seen in other neurologic conditions.

Patients who contract mid and lower facial muscles along with lid closure are said to have the syndrome of "blepharospasm-omandibular dystonia" first described by Meige in 1910.²¹ The term "dystonia" implies a more sustained contraction than a spasm. Such sustained contractions lead to abnormal postures which change as different muscle groups become involved. Blepharospasm is often an isolated initial sign, with progression to include tonic and clonic contractions of muscle groups variously involving the eyelids, eyebrows, lips, tongue, jaw, larynx and pharynx, neck and rarely the limbs.²²⁻²⁴ Marsden¹³ reported that of 30 cases of blepharospasm, 13 remained isolated while 17 showed dystonic features involving other facial and neck muscles. Blepharospasm was also reported as a common feature of the dystonic facial grimacing found in patients in the early stages of von Economo's encephalitis¹² which appeared in the decade following the 1919 influenza epidemic and has not been described since. The blepharospasm and facial dystonia preceded the later development of the signs of postencephalitic Parkinson's disease. The coexistence of blepharospasm and Parkinson's disease is actually rare. Blepharospasm has also been described as a rare manifestation of "tardive dyskinesias," a movement disorder characterized by facial grimacing, intermittent jaw opening, lip smacking, and tongue protrusion.²⁵ Tardive dyskinesias are seen either spontaneously in the elderly, after levodopa treatment in Parkinson's or, more commonly, after prolonged treatment of schizophrenics with neuroleptic medications, especially phenothiazines and butyrophenones.

Because of the neurologic diseases which manifest blepharospasm are believed to be mediated by a wide variety of different neurotransmitter dysfunctions, the pharmacotherapy of blepharospasm has included virtually every drug known to influence these neurochemical agents. Based on the misimpression that blepharospasm was often linked to Parkinson's disease, there was great hope that the success of L-dopa in treating that disease might apply to blepharospasm. It has not helped.

The next approach was to consider blepharospasm part of a hyperkinetic disorder like Huntington's chorea, tardive dyskinesia, or Gilles de la Tourette's disease which respond to dopaminergic antagonists such as haloperidol, reserpine and tetrabenazine. Beneficial results have thus far been sparse or transient.^{13,25,27} Since an antagonism between dopamine and acetylcholine has been recognized in Parkinson's and Huntington's diseases, several investigators have attempted to manipulate the cholinergic system in blepharospastic patients. Unfortunately, the use of cholinomimetic agents such as

physostigmine, choline chloride and lecithin has met with only limited success.^{26,27}

However, there is exciting preliminary evidence that centrally-acting anticholinergic agents may be more fruitful. Tanner et al²⁸ applied a rigorous protocol involving acute sequential administration of centrally acting anticholinergic and cholinergic agents to five patients whose signs were evaluated by masked viewers of videotapes. In four of five patients, dystonic signs clearly improved acutely after anticholinergic administration and worsened with cholinergic treatment. The acute response predicted reliably the effect of chronic anticholinergic treatment in these patients.

These favorable results are consistent with those observed recently in anticholinergic treatment of other dystonic diseases such as dystonia musculorum deformans²⁹ and spasmodic torticollis in small numbers of patients.³⁰

The anticholinergic used by Tanner et al²⁸ in the acute trials was scopolamine; in the chronic trials, lasting up to one year, they used benztropine or trihexyphenidyl. Nine of the 12 patients tested had sustained relief of signs, but in five of these patients, therapeutic dosages could not be maintained because of either severe memory loss, sedation, or dry mouth.

Several investigators have reported some success in treating Meige syndrome patients with baclofen, a gamma-aminobutyric acid (GABA) agonist.³¹ GABA is a central neurotransmitter with inhibitory effects. Baclofen relieves spasticity, helps in some cases of tardive dyskinesia, but its value in the dystonias is yet unproven.

Likening blepharospasm to a myoclonic disorder has led to the use of anticonvulsants. These have not generally helped, although two patients are reported to have responded to clonazepam (Clonopin) which contains sedative properties.³²

Mainstay of Treatment

Until a drug with lasting benefit at nontoxic dosage levels is found, the mainstay of treatment of blepharospasm will be ablation of the seventh cranial nerve.^{12-14,16,33,34} Alcohol injection at the junction of the seventh nerve branches and orbicularis oculi gives only temporary (3-6 months) relief; surgical section is effective if relatively proximal — either at the exit of seventh nerve from the stylomastoid foramen or in its intraparotid portion. More distal sectioning appears to be less effective, although Gillum and Anderson³⁵ recently described good results with extensive extirpation of the orbicularis oculi without neurectomy. Intracranial procedures are reserved for hemifacial spasm.

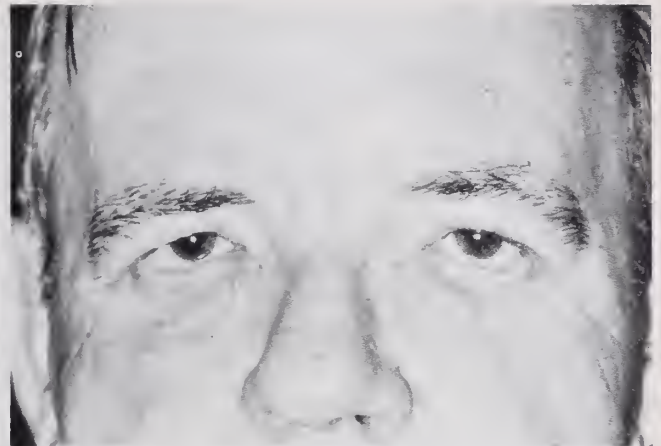


Fig. 2. — Same patient six weeks after bilateral selective facial neurectomy. Orbicularis oculi are now paralyzed so that eyes remain open (a). Note slight drooping of lower lids (b) producing mild corneal exposure requiring nightly instillation of ointment and lid taping.

The most commonly performed operation for essential blepharospasm is differential extirpation of branches in the parotid gland, with relative preservation of those fibers destined for the lower face. In a collective series of 100 cases, surgeons judged that blepharospasm was relieved in 69% of cases after one year and 61% at four years postoperatively.³⁴ Reoperations brought the success rate to a total of 75% at four years. In this series, the major complications were lower eyelid laxity (Fig. 2) (ectropion, 44%), paresis of the upper lip or drooping of the corner of the mouth (44%), and accentuation of upper eyelid dermatochalasis or brow droop (38%). About 50% of these complications were severe or persistent enough to require surgical correction, which was successful in all cases in averting permanent ocular complications.

My results with bilateral selective facial neurectomies on 21 patients at the University of Florida have been similar. The procedure is performed under general anesthesia and lasts about three hours. A six centimeter incision is made from the zygomatic arch to the angle of the mandible, two centimeters in front of the tragus. The branches of the seventh nerve are dissected from the parotid tissue (Fig. 3) and touched with a nerve stimulator. If a nerve has been correctly identified, the muscle it innervates will contract. All branches to the upper facial muscles are severed and extirpated by rolling them on a hemostat and pulling out their distal roots. If any branches are missed, the operation will eventually fail as collateral twigs reinnervate the bulk of muscle fibers.

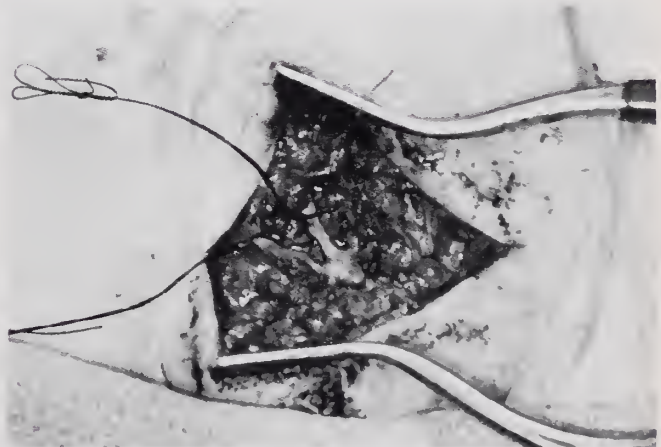


Fig. 3a, b. — Operative view showing dissection of parotid tissue, revealing branches of facial nerve. Branches innervating mid and upper facial muscles (not just orbicularis oculi), looped here by silk sutures, are identified with a nerve stimulator and extirpated by rolling them on a hemostat and avulsing the distal roots. Failure to identify and remove all such branches will impair success of the procedure.



Fig. 4. — Postoperative preauricular scar at incision site.

Wound healing presents no medical or cosmetic problems (Fig. 4), although a transient parotid-skin fistula is common.

Patients who have been debilitated by eyelid closure are so pleased they can now keep their eyes open that they are usually not disturbed by loss of facial expression or the usually mild problems with saliva control.

Among those who fail to obtain improvement with surgery in the early postoperative period are those whose orbicularis oculi remains functional (the innervating branches were inadequately or incompletely sectioned) and a perplexing group whose orbicularis is completely paralyzed and yet the eyelids remain closed! It appears that the levator palpebrae is not functioning — this is an upper lid opening problem rather than an accordion-like occlusion of the palpebral fissure. Patients in this group of nonresponders may sometimes be spotted before surgery by injecting a local anesthetic into the orbicularis oculi. Those who are unable to open their eyes after evident paresis of this muscle should not have surgery; the only recourse in such patients is placebo, drug or psychotherapy.

Conclusion

Blepharospasm remains an intriguing manifestation of a variety of pathologic states. The phenomenology of these states has become increasingly well-defined and promising drug therapy may soon be available for properly selected patients. The interplay between psychologic and neuropathologic features, and the response to manipulation of central neurotransmitters is reminiscent of

Huntington's chorea, Parkinson's disease, Gilles de la Tourette disease, and the dystonias. Based on the evidence so far, essential blepharospasm must be considered a forme fruste of an adult-onset idiopathic orofacial dystonia (Meige's syndrome) whose signs are, as with many other extrapyramidal diseases, exacerbated by emotionally trying circumstances. In its most flagrant state, it is a disabling affliction. Psychotherapy and drug therapy have not been effective enough in these patients, but may improve with greater understanding of the disease. Until that time, surgical ablation of the branches of the seventh nerve remains the treatment of choice, but should be reserved for the extremely debilitated because of some unpleasant side effects.

References

1. Goldstein, J.E., and Cogan, D.G.: Apraxia of Lid Opening. *Arch. Ophthalmol.* 73:155-159, 1965.
2. Fisher, C.M.: Reflex Blepharospasm. *Neurology* 13:77-82, 1963.
3. Irvine, A.R.; Daroff, R.B.; Sanders, M.D., and Hoyt, W.F.: Familial Reflex Blepharospasm. *Am. J. Ophthalmol.* 65:889-890, 1968.
4. Ferguson, J.H.: Hemifacial Spasm and Facial Nucleus. *Ann. Neurol.* 4:97-103, 1978.
5. Auger, R.G.: Hemifacial Spasm: Clinical and Electrophysiologic Observations. *Neurology* 29:1261-1272, 1979.
6. Jannetta, P.J.; Abbasy, M., and Maroon, J.C., et al: Etiology and Definitive Microsurgical Treatment of Hemifacial Spasm: Operative Techniques and Results in 47 Patients. *J. Neurosurg.* 47:321-328, 1977.
7. Waybright, E.A.; Gutmann, L., and Chou, S.M.: Facial Myokymia. Pathologic Features. *Arch. Neurol.* 36:244-245, 1979.
8. Boghen, D.; Filiatrault, R., and Descarries, L.: Myokymia and Facial Contracture in Brainstem Tuberculoma. *Neurology* 27:270-272, 1977.
9. Walsh, F.B., and Hoyt, W.F.: *Clinical Neuro-ophthalmology*. Williams & Williams, Baltimore, 1969, Vol. 1, pp. 345-346.
10. Langworthy, O.R.: Emotional Issues Related to Certain Cases of Blepharospasm and Facial Tics. *Arch. Neurol. Psychiatry* 68:620, 1952.
11. Shapiro, A.K.; Shapiro, E., and Wayne, H.L.S.: Symptomatology and Diagnosis of Gilles de la Tourette's Syndrome. *J. Am. Acad. Child Psychiatry* 12:702-723, 1973.
12. Henderson, J.W.: Essential Blepharospasm. *Trans. Am. Ophthalm. Soc.* 54:453-520, 1956.
13. Bird, A.C., and McDonald, W.I.: Essential Blepharospasm. *Trans. Ophthalm. Soc. U.K.* 95:250-253, 1975.
14. Coles, W.H.: Essential Blepharospasm. *So. Med. J.* 66:1407-1411, 1973.
15. Cavenar, J.O.; Brantley, I.J., and Braasch, E.: Blepharospasm: Organic or Functional? *Psychosomatics* 19:623-628, 1978.
16. Marsden, C.D.: Blepharospasm-oromandibular Dystonia Syndrome (Brueghel's Syndrome). Variant of Adult-onset Torsion Dystonia? *J. Neurol. Neurosurg. Psych.* 39:1204-1209, 1976.
17. Reckless, J.B.: Hysterical Blepharospasm Treated by Psychotherapy and Conditioning Procedures in Group Setting. *Psychosomatics* 13:263-264, 1972.
18. Sharpe, R.: Behavior Therapy in Case of Blepharospasm. *Brit. J. Psychiat.* 124:603-604, 1974.
19. Hardar, A., and Clancy, J.: Case Report of Successful Treatment of Reflex Trigeminal Nerve Blepharospasm. *Am. J. Ophthalmol.* 75:148-149, 1973.
20. Wickramasekera, I.: Hypnosis and Broad spectrum Behavior Therapy for Blepharospasm: A Case Study. *Int. J. Clin. Exp. Hypnosis* 22:201-209, 1974.
21. Meige, H.: Les Convulsions de la Face, une Forme Clinique de Convulsion Faciale, Bilatérale et Médiane. *Rev. Neurol. (Paris)* 10:437-443, 1910.
22. Tolosa, E.S.: Clinical Features of Meige's Disease (Idiopathic Orofacial Dystonia). Report of 17 Cases. *Arch. Neurol.* 38:147-151, 1981.
23. Paulson, G.W.: Meige's Syndrome. Dyskinesia of Eyelids and Facial Muscles. *Geriatrics* 27:69-73, 1972.
24. Coles, W.H.: Signs of Essential Blepharospasm. A Motion-picture Analysis. *Arch. Ophthalmol.* 95:1006-1007, 1977.
25. Crane, G.E.: Persistent Dyskinesia. *Brit. J. Psych.* 122:395-397, 1973.
26. Casey, D.E.: Pharmacology of Blepharospasm-oromandibular Dystonia Syndrome. *Neurology* 30:690-695, 1980.
27. Tolosa, E.S., and Lai, C.: Meige Disease: Striatal Dopaminergic Preponderance. *Neurology* 29:1126-1130, 1979.

28. Tanner, C.M.; Gantz, R.H., and Klawans, H.C.: Meige Disease: Acute and Chronic Cholinergic Effects. *Neurology (Supp.)* 31:78, 1981.
29. Fahn, J.: Use of High Dose Anticholinergics in Dystonia, *Neurology* 29:605, 1979.
30. Tanner, C.M.; Goetz, C.G., and Klawans, H.C.: Cholinergic Mechanisms in Spasmodic Torticollis. *Neurology* 29:604, 1979.
31. Goliomp, S.; Ilson, J., and Burke, R., et al: Meige Syndrome: Review of 31 Cases. *Neurology (Supp.)* 31:78, 1981.
32. Merikangas, J.R., and Reynolds, C.F.: Blepharospasm: Successful Treatment with Clonazepam. *Ann. Neurol.* 5:401-402, 1979.
33. Reynolds, D.H.; Smith, J.C., and Walsh, T.J.: Differential Section of Facial Nerve for Blepharospasm. *Tr. Am. Acad. Ophthal. Otolaryn.* 71:656-664, 1967.
34. Frueh, B.R.; Callahan, A., and Dortzbach, R.K., et al.: Effects of Differential Section of Seventh Nerve on Patients with Intractable Blepharospasm. *Tr. Am. Acad. Ophthal. Otolaryn.* 81:597-602, 1976.
35. Gillum, W.N., and Anderson, R.L.: Blepharospasm Surgery. *Arch. Ophthal.* 99:1056-1062, 1981.

● Dr. Trobe, Department of Ophthalmology, Box J-284, JHMH, Gainesville 32610.

Echocardiographic Evaluation in Surgically Treated Infective Endocarditis

W. Daniel Doty, M.D., Abe W. Friedman, M.D. and Robert Samuel Cromartie III, M.D.

Abstract: Cardiac catheterization has traditionally been performed in the majority of patients prior to cardiac surgery. The risk with infective endocarditis has not been clearly defined but may be significant. Advances in techniques of echocardiography have made it possible to select certain patients for cardiac valve replacement without catheterization. Presented here is a patient with bacterial endocarditis involving the tricuspid valve who underwent valve replacement and had a definitive diagnosis made by echocardiography. The echocardiographic findings consistent with endocarditis are categorized and reviewed.

The patient, a 53-year-old white male, underwent prolonged hospitalization for unexplained persistent sepsis. He had presented with daily spiking fever after an unexplained rash and transient infection of both ear lobes. There was no history of other recent infection or drug addiction. Initial physical examination revealed fever, tachycardia, hypotension, and a pericardial friction rub but no heart murmur or evidence of peripheral emboli. Blood cultures grew *Staphylococcus aureus* and he received Keflin, two grams, parenterally, every four hours for two weeks. Cultures while the patient was on antibiotics grew *enterobacter aerogenes*, and his therapy was changed to chloramphenicol and gentamicin. Abdominal CT scan, Gallium scan, brain scan, and lung scan were all negative. M-mode echocardiography revealed no abnormalities, though the examination was technically difficult. Bilateral infiltrates became evident on chest roentgenograms and anemia and acute renal failure evolved, despite decreasing his gentamicin dose.

After four weeks hospitalization, he was transferred to the Veterans Administration Hospital, Indianapolis, where physical examination revealed fever, moderate jugular venous distention, diffuse rhonchi and rales over both lungs, and a Grade I-II/VI apical systolic murmur. No Roth's spots were seen. Chest roentgenogram showed infiltrates in the right lower lobe and a right pleural effusion. Thoracentesis yielded serosanguineous fluid which grew *Staphylococcus aureus*, as did multiple blood cultures. Repeat M-mode echocardiography revealed increased echoes from the tricuspid valve apparatus (Fig. 1). The two-dimensional echocardiogram, obtained with a 30° mechanical scanner, demonstrated a large mass lesion attached to the tricuspid valve which moved back and forth between the right atrium and ventricle (Figs. 2 and 3). The presumptive diagnosis was tricuspid endocarditis with septic pulmonary emboli. Because of the size and pedunculated nature of the mass, infected atrial myxoma of the tricuspid valve was also considered. Cardiac catheterization was not performed.

Because of persistent fever, septic pulmonary emboli and renal deterioration, the patient was taken to surgery where he underwent median sternotomy, cardiopulmonary bypass, and tricuspid valve replacement with a size 33 Carpentier-Edwards porcine prosthesis. The tricuspid valve was totally incompetent with one flail leaflet and multiple small vegetations seen grossly at surgery. None of the vegetations, however, were as large as the mass seen on the two-dimensional echocardiogram performed one week prior to surgery. This discrepancy was presumably due to the mass-like appearance of the flail tricuspid valve or possibly due to

The Authors

W. DANIEL DOTY, M.D.

Dr. Doty is Clinical Instructor of Medicine, Pensacola Education Program, Division of Cardiology, Baptist Hospital and Sacred Heart Hospital, Pensacola.

ABE W. FRIEDMAN, M.D.

Dr. Friedman is Clinical Instructor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pa.

ROBERT SAMUEL CROMARTIE III, M.D.

Dr. Cromartie is in the Division of Thoracic and Cardiovascular Surgery at Ormond Beach Memorial Hospital, Ormond Beach.

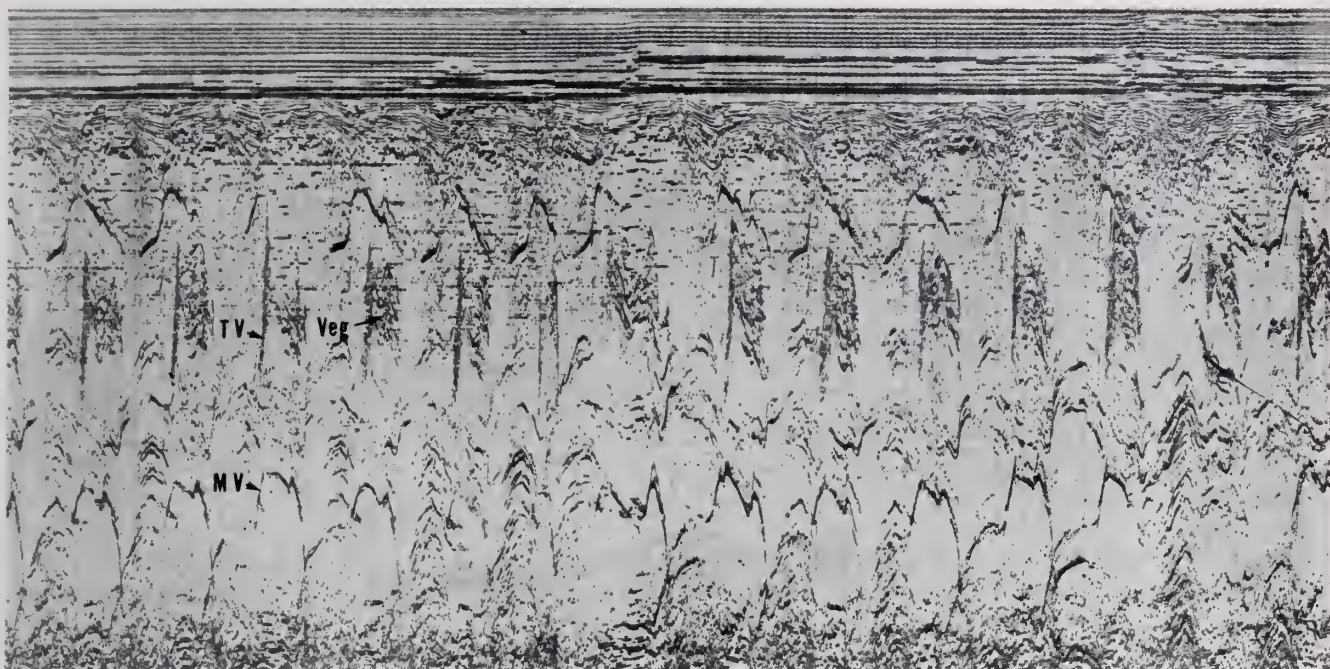


Fig. 1. — M-mode echocardiogram through the tricuspid (TV) and mitral (MV) valves. Note the mass of "shaggy" echoes seen in the region of the tricuspid valve, particularly in diastole.

embolization of part of the vegetation. Pathologic study of the valve leaflets revealed many neutrophils and occasional macrophages consistent with endocarditis. Bacterial cultures of the surgical specimen were sterile.

Postoperatively, the patient became afebrile and had no further evidence of pulmonary emboli. He remained in the hospital for six weeks of further antibiotic therapy with parenteral nafcillin. Renal function gradually improved with his blood urea nitrogen falling from a preoperative value of 105 to 25 mg% and creatinine from 8.8 to 1.9 mg% at discharge. He has subsequently done well.

Discussion

Although the morbidity and mortality from infective endocarditis have been significantly improved by antibiotic therapy, many patients suffer from persistent infection or complications of endocarditis despite optimal medical therapy. Surgical therapy has been used with increasing frequency, even in the face of active infection, for eradication of infection as well as prevention of the complications of endocarditis.¹⁻³ The indications for surgical intervention, however, remain controversial. Congestive heart failure remains the major cause of failure of medical therapy and the most frequent indication for surgical intervention; other indications include persistent sepsis, life-threatening extravascular infections, embolic episodes and dysfunction of a previously

inserted prosthetic valve.¹⁻⁵ Some authors advocate more aggressive intervention for infection with extremely virulent or drug-resistant organisms, particularly *Staphylococcus aureus* or fungi, and for prosthetic or aortic valve endocarditis.^{4,5}

Isolated right-sided endocarditis is relatively infrequent, occurring in only two to five percent of cases,^{6,7} most commonly involving the tricuspid valve,^{8,9} and generally presenting as an acute rather than a subacute process.⁶ *Staphylococcus aureus* is the most common infecting organism.^{6,8,9} Right-sided endocarditis is usually seen in the setting of intravenous drug abuse; other reported predisposing factors are alcohol abuse, virulent skin infections, infected venous catheters, and congenital heart disease, particularly patent ductus arteriosus, ventricular septal defect, tetralogy of Fallot and pulmonic stenosis.^{6,8-10}

The clinical diagnosis of tricuspid endocarditis is suggested by the triad of fever, narcotic addiction, and multiple lung lesions.¹¹ A pathological cardiac murmur, generally the most helpful clue in alerting the clinician to the possibility of endocarditis, is frequently absent in isolated tricuspid valve involvement. In patients with isolated right-sided endocarditis, Bain et al found that a murmur was absent in 65%.⁶ The murmur of tricuspid insufficiency was missed, unrecognized, or absent in 16 of 42 patients with proven tricuspid involvement reported

by Banks et al.⁹ Though significant tricuspid leaflet damage and ruptured chordae tendineae are fairly common, the low pressure gradient between the right ventricle and atrium may be responsible for the frequent absence of a murmur.⁸ The presence of a murmur, on the other hand, is not necessarily indicative of valvular destruction.¹²

Other features of right-sided endocarditis may also obscure the diagnosis. Severe congestive heart failure is less common with right-sided valvular lesions, and blood cultures are negative in a significant percentage of patients.⁴ Thus, the absence of a pathological murmur, obvious hemodynamic compromise and positive blood cultures can make the diagnosis of right-sided endocarditis very difficult. Extensive pulmonary embolization and generalized sepsis, the most common causes of death,⁶ frequently occur prior to a definitive diagnosis. Congestive heart failure is a less frequent indication for surgery in right-sided endocarditis while septic pulmonary emboli and persistent fever and sepsis more commonly necessitate surgical therapy.¹⁻⁵

Cardiac catheterization has been used to identify and localize vegetations and evaluate hemodynamic and valvular function in endocarditis. Welton et al have recently reported a series of patients with active endocarditis in whom catheterization was performed without significant complications.¹³ Others have reported, however, that the manipulation of catheters in the region of friable vegetations is accompanied by a significant risk of pulmonary or systemic embolization.^{4,9,10} The other major reported risk of catheterization in endocarditis is further depression of cardiac function by angiography, which has led to serious and even fatal consequences in hemodynamically compromised patients.^{4,14} The data obtained by catheterization is also believed by some authors to be of limited value, particularly in localizing the sites of vegetations.¹⁴ Though the precise risk of cardiac catheterization in infective endocarditis is not well defined, it would appear that the risk is significant and that catheterization is not justified in all patients in whom surgery is contemplated; catheterization is still necessary, however, in the majority of surgical patients.

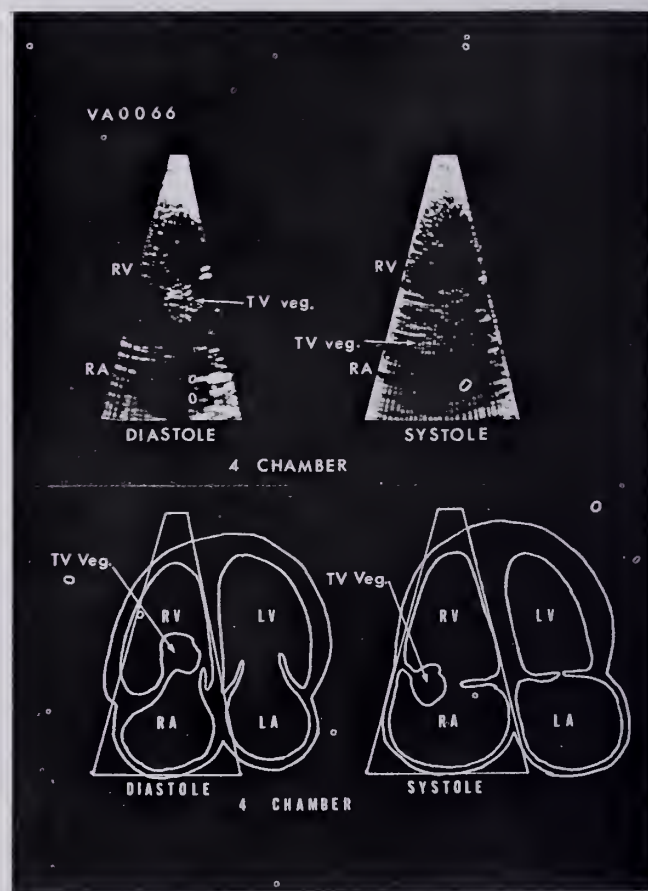
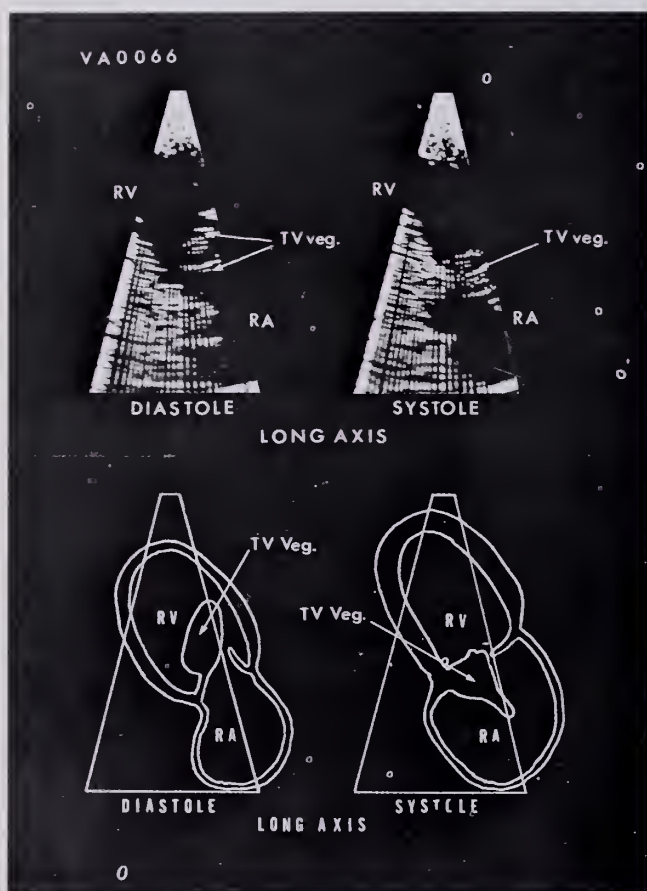


Fig. 2. — Two-dimensional echocardiogram of the long axis of the right ventricle (RV) and atrium (RA). Note the large pedunculated vegetation oscillating with the tricuspid valve between chambers.

Fig. 3. — Two-dimensional echocardiogram taken in the four chamber view from the apex. A large mobile mass is seen attached to the tricuspid valve.

Echocardiography has offered the first noninvasive means of directly localizing and characterizing vegetations in endocarditis. It is also capable of detecting cardiac complications associated with endocarditis, assessing cardiac hemodynamics and function and identifying preexisting valvular abnormalities. The sensitivity of echocardiography in detecting vegetations has been reported to range from 34% to 82%,¹⁵⁻¹⁹ though all reported series suffer from some bias due to patient selection or a retrospective analysis. M-mode and two-dimensional echocardiography appear to be about equally sensitive in detecting vegetations,¹⁷ though some instances are reported in which vegetations were seen with one technique but not the other. The vegetations identified by echocardiography have generally been 2 mm or greater in size and pathologically proven vegetations of 1 mm in diameter have been missed, possibly accounting for some lack of sensitivity.^{17, 20, 21}

Less information is available regarding the specificity of echocardiography in identifying vegetations. In a series of 17 patients with endocarditis with a total of 20 involved valves, there was only one valve identified as a false positive among the remaining uninvolved valves.¹⁶ In patients with mitral valve prolapse and myxomatous mitral degeneration, however, the echo is of limited value in diagnosing vegetations because of a very high incidence of false positives.²² Valve calcification and thickening and myxoma have also been mistaken for vegetations.¹⁸

The echocardiographic characteristics of endocarditis are outlined in Table 1. The diagnosis may be suspected either by direct visualization of the valvular vegetations or by identification of associated cardiac complications or hemodynamic manifestations. The two-dimensional echocardiogram has been felt to be better at characterizing the shape and mobility of vegetations, while the M-mode echocardiogram has been considered more sensitive in detecting associated abnormalities such as premature mitral valve closure in severe aortic insufficiency or fine diastolic aortic valve fluttering seen with a perforated aortic valve cusp.¹⁷ Though tricuspid vegetations are generally larger than mitral vegetations, the echocardiogram has been less sensitive in detecting tricuspid vegetations,²³ perhaps due to greater technical difficulty in examining the tricuspid valve.

The role of the echocardiogram as an indication for surgical therapy in endocarditis remains undefined. Wann et al found a higher incidence of mortality or necessity of surgical therapy in patients who had vegetations identified by echo and concluded that an abnormal echocardiogram may identify patients with more severe disease.¹⁹ In a later series, also reported by Wann et al,¹⁷ the size and shape of the vegetation did not accurately predict the need for early valve replacement or the inci-

dence of major peripheral emboli. The authors concluded that the identification of even large vegetations by echocardiography is not yet in itself an indication for surgery.

Previous case reports of surgically treated tricuspid valve endocarditis have been patients who either underwent catheterization prior to surgery or had a more typical clinical presentation with a known history of intravenous drug abuse.^{7, 10, 12, 24-26} The diagnosis of tricuspid endocarditis in the patient presented was initially difficult because of the absence of a pathological murmur or the usual history of drug addiction. Only after significant morbidity with septic emboli and persistent infection was the diagnosis clinically apparent. The echocardiogram provided dramatic identification of the site of the vegetation and assessment of overall cardiac function, allowing surgical intervention without the risk or necessity of catheterization. Although the patient presented underwent valve replacement, some patients with protracted persistent infection due to tricuspid endocarditis have been treated with valvectomy alone with apparently good results.^{29, 30}

It is noteworthy that the initial echocardiogram failed to identify the valvular vegetations. As in this instance, right-sided cardiac valves may be technically difficult to visualize. Cardiac lesions can also be missed, however, by failure to routinely perform a complete echocardiographic examination.

Summary

Surgical therapy for infective endocarditis has been used with increasing frequency despite dramatically improved results of medical treatment; surgery is now commonly undertaken early in the course of active endocarditis. Both the criteria for diagnosis and the indications for surgical intervention have depended largely upon the secondary effects or complications of endocarditis, which often manifest only after significant morbidity has occurred. Cardiac catheterization in the face of infective endocarditis appears to carry a significant, though incompletely defined, risk of morbidity and mortality. The risk of cardiac catheterization in some patients may outweigh the benefits particularly when there is little chance of obtaining additional worthwhile information or when the risk of vegetation dislodgement or hemodynamic compromise is particularly high.

Echocardiography provides a means of localizing and characterizing vegetations, documenting complications and assessing cardiac function in patients with endocarditis. Echocardiographic information may reduce the danger of catheterization by identifying friable vegetations or by supplying information which may obviate some portions of the catheterization. The echocardiogram may serve as the definitive preoperative diagnostic procedure in selected patients in whom the risks of catheterization outweigh the benefits.

Table 1. — Echocardiographic Characteristics
of Endocarditis.

M-mode Echocardiogram		Two-Dimensional Echocardiogram	
A. Vegetations and valvular abnormalities		A. Vegetations and valvular abnormalities	
1. "Shaggy" or "smudgy" echoes ^{15,21,23,26,27}		1. Rapid, high-frequency oscillations ^{18,20}	
2. Irregular, nonuniform valvular thickening ^{18,21,27}		2. Destruction of leaflet integrity ²⁰	
3. Unrestricted, normal or chaotic valve motion ^{15,18,27}		B. Associated findings	
B. Associated findings		Aortic	
Aortic		1. Flail aortic cusp (rapidly moving high-intensity mass attached to one of the aortic cusps) ¹⁸	
1. Left ventricular volume overload (dilatation of the LV with exaggerated wall motion) ¹⁵		2. Aortic root abscess (double density of posterior aortic wall) ¹⁸	
2. Prolapsing aortic valve leaflet or aortic vegetation (coarsely fluttering echoes in the LV outflow tract) ¹⁵		3. Ruptured sinus of valsalva aneurysm (outpouching of aorta into right atrium) ¹⁸	
3. Severe aortic insufficiency (premature mitral valve closure with diastolic mitral fluttering) ^{15,27}		4. Left ventricular volume overload (dilatation and exaggerated wall motion)	
4. Torn, fenestrated, or perforated cusp (fine diastolic fluttering of the aortic valve) ^{17,19,23,27}		Mitral	
5. Aortic root abscess (double density of posterior aortic wall) ¹⁸		1. Left ventricular volume overload	
Mitral		2. Flail mitral valve leaflet (free edge of valve moving into atrium during systole) ¹⁸	
1. Left ventricular volume overload ¹⁵		Tricuspid and Pulmonic	
2. Ruptured chordae tendineae and flail leaflets		1. Right ventricular volume overload (dilated RV with paradoxical septal motion)	
a. Systolic intracavitary left atrial echoes ^{18,27,28}		2. Flail tricuspid valve leaflet	
b. Increased systolic excursion of left atrial wall ²⁸			
c. Increased ejection fraction, stroke volume and interventricular septal wall motion ²⁸			
d. Abnormal coaptation and exaggerated motion of anterior mitral leaflet ²⁸			
e. Fine systolic mitral valve fluttering ^{18,27}			
f. Coarse diastolic anterior mitral valve fluttering ¹⁸			
g. Chaotic diastolic posterior mitral valve motion ¹⁸			
h. Marked holosystolic mitral valve prolapse ^{18,23}			
i. Erratic diastolic valve opening movements ²³			
Tricuspid and Pulmonic			
1. Right ventricular volume overload (RV dilatation with paradoxical interventricular septal motion) ²⁶			
2. Excessive systolic tricuspid valve separation ¹⁸			

References

- Black, S.; O'Rourke, R.A. and Karlner, J.S.: Role of Surgery in Treatment of Primary Infective Endocarditis, *Am. J. Med.* 56:357-369, 1974.
- Jung, J.Y.; Dalim, B.S. and Almond, C.H.: Case for Early Surgical Treatment of Left-Sided Primary Infective Endocarditis, *J. Thorac. Cardiovasc. Surg.* 70:509-517, 1975.
- Boyd, A.D., et al: Infective Endocarditis. Analysis of 54 Surgically Treated Patients, *J. Thorac. Cardiovasc. Surg.* 73:23-29, 1977.
- Gregoratos, G. and Karlner, J.S.: Infective Endocarditis. Diagnosis and Management, *Med. Clin. N. Am.* 63:173-199, 1979.
- Richardson, J.V.; Karp, R.B.; Kirklin, J.W. and Dismukes, W.E.: Treatment of Infective Endocarditis: A 10-year Comparative Analysis, *Circulation* 58:589-597, 1978.
- Bain, R.C.; Edwards, J.E.; Scheifley, C.H. and Geraci, J.E.: Right-Sided Bacterial Endocarditis and Endarteritis, *Am. J. Med.* 24:98-110, 1958.
- Vidne, B. and Levy, M.J.: Tricuspid Valve Endocarditis. Prosthetic Replacement, *J. Thorac. Cardiovasc. Surg.* 68:47-50, 1974.
- Roberts, W.C. and Buchbinder, N.A.: Right-Sided Valvular Infective Endocarditis, *Am. J. Med.* 53:7-19, 1972.
- Banks, T.; Fletcher, R. and Ali, N.: Infective Endocarditis in Heroin Addicts, *Am. J. Med.* 55:444-451, 1973.
- Ellis, K.; Jaffe, C.; Malm, J.R. and Bowman, F.O.: Infective Endocarditis. Roentgenographic Considerations, *Radiol. Clin. N. Am.* 11:514-442, 1973.
- Wright, J.S. and Glennie, J.S.: Excision of Tricuspid Valve with Later Replacement in Endocarditis of Drug Addiction, *Thorax.* 33:415-519, 1978.
- Chandraratna, R.A.N.; Reagan, R.B.; Imaizumi, T.; Langevin, E. and Elkins, R.C.: Infective Endocarditis Cured by Resection of Tricuspid Valve Vegetation, *Ann. Int. Med.* 89:517-518, 1978.

13. Welton, D.E., et al: Value and Safety of Cardiac Catheterization During Active Infective Endocarditis, *Am. J. Cardiol.* 44:1306-1310, 1979.
14. Mills, J.; Abbott, J.; Utley, J.R. and Ryan, C.: Role of Cardiac Catheterization in Infective Endocarditis, *Chest* 72:576-582, 1977.
15. Roy, P.; Tajik, A.J.; Giuliani, E.R.; Schattenbert, T.T.; Gau, G.T. and Frye, R.L.: Spectrum of Echocardiographic Findings in Bacterial Endocarditis, *Circulation* 53:474-482, 1976.
16. Thompson, K.; Nanda, N. and Gramiak, R.: Reliability of Echocardiography in Diagnosis of Infective Endocarditis (abstr.), *Circulation Suppl.* II 53:54-II 112, 1976.
17. Wann, L.S.; Hallam, C.C.; Dillon, J.C.; Weyman, A.E. and Feigenbaum, H.: Comparison of M-mode and Cross Sectional Echocardiography in Infective Endocarditis, *Circulation* 60:728-733, 1979.
18. Mintz, G.S.; Kotler, M.N.; Segal, B.L. and Parry, W.R.: Comparison of Two-Dimensional and M-mode Echocardiography in Evaluation of Patients with Infective Endocarditis, *Am. J. Cardiol.* 43:738-744, 1979.
19. Wann, L.S.; Dillon, J.C.; Weyman, A.E. and Feigenbaum, H.: Echocardiography in Bacterial Endocarditis, *N. England J. Med.* 295:135-299, 1976.
20. Gilbert, B.W., et al: Two Dimensional Echocardiographic Assessment of Vegetative Endocarditis, *Circulation* 55:346-353, 1977.
21. Dillon, J.C.; Feigenbaum, H.; Konecke, L.L.; Davis, R.H. and Chang, S.: Echocardiographic Manifestations of Valvular Vegetations, *Am. Heart J.* 86:698-704, 1973.
22. Chandraratna, P.A.N. and Langevin, E.: Limitations of Echocardiogram in Diagnosing Valvular Vegetations in Patients with Mitral Valve Prolapse, *Circulation* 56:436-438, 1977.
23. Andy, J.J., et al: Echocardiographic Observations in Opiate Addicts with Active Infective Endocarditis, *Am. J. Cardiol.* 40:17-23, 1977.
24. Crawford, F.A.; Wechsler, A.S. and Kisslo, J.A.: Tricuspid Endocarditis in Drug Addict: Detection of Tricuspid Vegetations by Two Dimensional Echocardiography, *Chest* 74:473-475, 1978.
25. Lee, C.C.; Ganguly, S.N.; Magnisalis, K. and Robin, E.: Detection of Tricuspid Valve Vegetations by Echocardiography, *Chest* 66:432-433, 1974.
26. Sheikh, M.U.; Ali, N.; Covarrubias, E.; Fox, L.M.; Morjaria, M. and Dejo, J.: Right-Sided Infective Endocarditis, Echocardiographic Study. *Am. J. Med.* 62:283-287, 1979.
27. Dillon, J.C.: Echocardiography in Valvular Vegetations, *Am. J. Med.* 62:856-862, 1977.
28. Sweatmen, T.; Selzer, A.; Kamagaki, M. and Cohn, K.: Echocardiographic Diagnosis of Mitral Regurgitation Due to Ruptured Chordae Tendineae, *Circulation* 66:580-585, 1972.
29. Sethia, B. and Williams, B.T.: Tricuspid Valve Excision Without Replacement in Case of Endocarditis Secondary to Drug Abuse, *Brit. Heart J.* 40:579, 1978.
30. Arbulu, A.; Thomas, N.W. and Wilson, R.F.: Valvectomy Without Prosthetic Replacement. Lifesaving Operation for Tricuspid Pseudomonas Endocarditis, *J. Thorac. Cardiovasc. Surg.* 64:103, 1972.

● Dr. Cromartie, 550 Memorial Circle, Suite M, Ormond Beach 32074.

Isolated Rupture of Extensor Pollicis Longus Case Report

Issa F. Baroudi, M.D.

Abstract: A case is presented of isolated rupture of the extensor pollicis longus tendon in a 24-year-old male who was treated with tendon graft with satisfactory functional results.

Spontaneous rupture of the extensor pollicis longus tendon is rare. Previous reports have implicated either wrist fractures¹ or degeneration associated with rheumatoid arthritis.²⁻⁵ In the following case, rupture of the extensor pollicis longus tendon occurred without either of these entities.

Report of Case

In August 1979, a 24-year-old black male presented with the complaint of weakness of the left thumb and inability to keep it straight (Fig. 1). A well known baseball player, he stated the problem started three weeks previously after a practice when he took off his catcher's mitt. He was evaluated at a local hospital and x-rays of the wrist were reported as within normal limits. Initial evaluation in the Hand Clinic revealed weakness of adduction of the left thumb, drooping of the distal phalanx, ill-defined dorsoulnar margin of the snuffbox, and inability to "hitchhike" (hyperextend his thumb). There were no points of tenderness, swelling or deformity. The patient denied any previous injury or other symptomatology about the wrist.

Exploration of the extensor mechanism of the thumb revealed complete rupture of the extensor pollicis longus with a gap of 8 cm. There was no evidence of associated synovitis and tendon ends were sharp. Repair with palmaris longus tendon as a graft was performed (Fig. 2). Immobilization by plaster cast with hyperextension of the thumb for five weeks was employed. Follow-up over a six-month period showed functional aspects to be excellent (Fig. 3).

Discussion

Treatment of ruptured extensor pollicis longus of the thumb will vary from patient to patient and depend upon findings at time of surgery. In this case end-to-end repair was impossible due to the wide retraction of the tendon ends. Tendon graft was elected taking into consideration the patient's age and a healthy muscle belly found at the time of surgery. Transfer of extensor indices could be another alternative.

Conclusion

The extensor pollicis longus of the thumb can be ruptured without associated pathology, as previously reported. There is a possibility of a new entity as this case indicates.



Fig. 1. — Preoperative picture showing lack of thumb extension.

The Author

ISSA F. BAROUDI, M.D.

Dr. Baroudi is a practicing Plastic and Reconstructive Surgeon in Port Charlotte.



Fig. 2. — Intraoperative picture showing tendon graft.



Fig. 3. — Postoperative picture showing excellent return of function.

References

1. Converse, J.M.: *Reconstructive Plastic Surgery. Rupture of Extensor Pollicis Longus Following a Colle's Fracture.* Philadelphia, W.B. Saunders Co., 1977.
2. Laine, V.A.I. and Vaino, K.J.: Spontaneous Ruptures of Tendons in Rheumatoid Arthritis, *ACTA Orthop. Scand.* 24:250, 1955.
3. Straub, L.R. and Wilson, E.H.: Spontaneous Rupture of Extensor Tendons in Hand Associated with Rheumatoid Arthritis, *J. Bone Joint Surg.* 38A:1208, 1956.
4. Ehrlich, G.E.; Peterson, L.T.; Sokoloff, L. and Buning, J.J.: Pathogenesis of Rupture of Extensor Tendons at Wrist in Rheumatoid Arthritis, *Arthritis Rheum.* 2:332, 1959.
5. Kilgore, E.S. and Graham, W.P.: *The Hand: Surgical and Nonsurgical Management.* Philadelphia, Lea and Febiger, 1977, p. 395.

● Dr. Baroudi, St. Joseph Hospital, 601 Northeast Harbor Boulevard, Port Charlotte 33952.

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE
SEVENTEENTH ANNUAL POSTGRADUATE COURSE
“Internal Medicine 1982”
February 21-26, 1982

SHERATON BAL HARBOUR HOTEL MIAMI BEACH, FLORIDA

THE OBJECT OF THIS COURSE, THE SEVENTEENTH IN ITS SERIES, IS TO PROVIDE AN ANNUAL UPDATING OF THE MOST USEFUL RECENT ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF INTERNAL MEDICAL DISORDERS AS THEY ARE ENCOUNTERED BY PRIMARY CARE PHYSICIANS AND PRACTICING SPECIALISTS.

GUEST FACULTY

Sidney Cohen, M.D.
Professor of Medicine
University of Pennsylvania
School of Medicine
Philadelphia, PA

Robert A. Good, M.D.
Professor of Medicine and Pediatrics
Cornell University
Medical College
New York, NY

Seymour Reichlin, M.D.
Professor of Medicine
Tufts University
School of Medicine
Boston, MA

Martin Goldberg, M.D.
Taylor Professor of Medicine and Chairman,
Department of Internal Medicine
University of Cincinnati College of Medicine
Cincinnati, OH

Sol Sherry, M.D.
Professor of Medicine
Chairman, Department of Medicine
Temple University School of Medicine
Philadelphia, PA

HIGHLIGHTS

**VIDEOTAPE REVIEW OF
TOPICS
FOR BOARD REVIEW
IN INTERNAL MEDICINE**

Selected topics in Internal Medicine updated by the University of Miami faculty and primarily designed for physicians preparing for Board certification in Internal Medicine will be shown on a large TV screen.

FIVE MAJOR SYMPOSIUMS

Five major symposiums will present the newest developments in selected areas of internal medicine.

**MEET THE FACULTY SESSIONS
“CRITICAL CARE IN INTERNAL
MEDICINE”**

Simultaneous group meetings will present topics of **CRITICAL CARE IN INTERNAL MEDICINE**. Special emphasis will be given to the most recent advances in the management of the critically ill patient.

**PICTORIAL QUIZ * AUDIOVISUAL AIDS * SCIENTIFIC EXHIBITS
HOTEL ATTRACTIONS * SPOUSES ACTIVITIES**

38 Lecture Hours and 20 Self-Instruction Credit Hours, Category I, A.M.A.

REGISTRATION:

\$400/Physician

\$250/Physician in Training (letter from Chief of Service must accompany registration)

FOR REGISTRATION AND INFORMATION WRITE TO:

Jose S. Bocles, M.D.
Department of Medicine R760
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101
Phone: (305) 547-6063

The FMA Retired Lives Reserve: An Innovative Plan to Insure Your Future

Sanford A. Mullen, M.D.

In medicine, perhaps more than in any other field, we experience almost constant innovation. It could probably be said, in fact, that physicians practice their art a little differently each day in response to the new materials and methods being introduced. Yet, while the doctor remains up-to-date on the tools and technology that insure the best patient care, he or she is often uninformed — because of the demands on time — about the modern financial planning tools that are equally important to running a successful practice.

Mindful of the physician's need for innovative financial planning services, the Florida Medical Association is pleased to introduce a pioneering insurance program that offers physicians the significant benefits of a tax-favored approach to lifelong, post-retirement insurance protection. That program is the FMA-sponsored Retired Lives Reserve (RLR), being offered exclusively to our members by MAPS — the Mutual Association for Professional Services — and the Penn Mutual Life Insurance Company, in connection with PIMCO.

To understand the unique strengths of the RLR, it is important to look at the weaknesses of conventional group term life insurance. The most compelling of these is that group term life insurance, paid throughout your entire working life, often returns very little benefit to you upon retirement. With most conventional policies, in fact, your coverage is cancelled entirely or dramatically reduced upon retirement. And, even if you are eligible

to purchase individual insurance at that age, the cost is extremely high and increases dramatically each year thereafter. Thus physicians with group term life insurance who live beyond retirement may have little or no benefit to leave to their heirs.

Since most of you have received, by now, a descriptive mailing on the FMA-sponsored RLR program, you may already be familiar with the solutions it offers to these problems. There are five major benefits with the RLR plan: (1) Most members will be able to get up to \$300,000 post-retirement group life insurance coverage. (2) Incorporated members will be able to deduct their premium payments as a business expense, so the actual cost of the program will be reduced. (3) The RLR requires no premium payments after retirement, yet (4) the coverage continues and the insurance remains in force unchanged to age 100. This assures that your family will always be protected financially. (5) There is no need to change your present group life insurance program because this is a "wrap-around" plan.

It is important for physicians to understand the distinctions between the RLR program and conventional policies. Tragedy can occur when professionals believe, erroneously, that because they're enrolled in a group term life insurance plan during their working years, their families are covered even after they retire. Look at the hypothetical case of Dr. Jones. The doctor had \$200,000 worth of conventional group term life insurance provided to him by his professional corporation for many years as part of a plan for all of the corporation's eight employees. As with most plans, half of his coverage was terminated upon his retirement and the policy was cancelled entirely when Dr. Jones reached age 70. When he died at age 74, there was no coverage for his wife, a tragedy since a lot of money was paid into the plan over the years and his

The Author

SANFORD A. MULLEN, M.D.

Dr. Mullen, of Jacksonville, is President of the Florida Medical Association, Inc.

wife desperately needed the funds. Since Dr. Jones believed he had \$200,000 worth of life insurance protection, he failed to arrange for permanent life insurance while he was working. Once he had retired, the cost of converting the group term life to permanent insurance was just too expensive.

These tragedies need not occur. Another physician, Dr. Smith, also practices with a professional corporation, but his company is adopting an RLR group insurance plan. His \$200,000 worth of group term life insurance is structured to stay in effect until his death, not just until retirement. Dr. Smith's corporation deposits monies every year so that when he and other employees retire, the cost of their continued coverage is paid from the reserve fund until their deaths. Under existing law and rulings, Dr. Smith's corporation is able to deduct not only the group term premiums, but also the reserve contributions as they are made. This special tax advantage immediately reduces the cost of the insurance program by as much as 50 percent.

Dr. Smith has lifelong coverage and, when he dies, his survivors are guaranteed to receive the full \$200,000 value of his policy. Dr. Smith has designated his wife as beneficiary so that upon Dr. Smith's death, Mrs. Smith will receive the \$200,000 free of all income and estate tax. That \$200,000 could generate about \$30,000 worth of earnings for Mrs. Smith. Mrs. Jones, you'll remember, had nothing.

According to Max B. Lewis, J.D., a nationally recognized authority on estate planning, the RLR program marries the group term concept of tax-favored employer-provided term insurance with the whole life insurance concept of lifelong coverage. Permanent whole life insurance, if kept in force, is an absolute promise to pay upon the death of the insured; group term life insurance is a

promise to pay only if the insured dies "too soon" and under the typical group life program it cannot be kept in force for life. RLR is particularly cost effective since it combines low-cost and lifetime coverage features and offers special tax advantages.

While the details and benefits of the FMA-sponsored RLR are too complex to discuss fully here, the examples of Drs. Jones and Smith should give you an idea of how dramatically insurance policies can differ and how devastating a poor choice of coverage can be. The FMA strongly encourages all members to reevaluate their estate plans now that this RLR program is available to you. What appeared to be the best plan at one time may now be outmoded by this new coverage and the effects of the new tax legislation.

The Florida Medical Association-sponsored RLR presents an opportunity to provide permanent benefits to your family on a tax-favored cost basis. That, in itself, is a boon, but the value multiplies when you consider that, knowing you have such a permanent benefit, you can use your other funds for investment or personal enjoyment.

If you're interested in the RLR concept, PIMCO will put you in contact with your MAPS service representative to evaluate your estate plan and provide you with more information on the potential design and costs of an RLR program for your practice. MAPS representatives are highly skilled professionals who can tap the wealth of experience of MAPS and The Penn Mutual Life Insurance Company in setting up a custom plan for you.

Discuss the concept with your own legal and tax advisors. They will also help you determine if RLR is the kind of innovation you can benefit from.

- Dr. Mullen, P.O. Box 2921, Jacksonville 32203.

Agent Orange: What's It All About?

Franklin P. Flowers, M.D., Neil A. Fenske, M.D., and Pattye A. Whisman, M.D.

There were approximately 2.4 million Americans directly involved in the Vietnam War. Many suffered devastating physical and emotional injury. An untold number have or possibly will suffer damage from Agent Orange.

Agent Orange was used as a defoliant in Vietnam from the mid-1960's until 1971, when the Pentagon called a halt to its use. Agent Orange is a code name for a herbicide containing equal parts of 2, 4, 5-trichlorophenoxyacetic acid (2, 4, 5-T) and 2, 4-dichlorophenoxyacetic acid (2, 4-D). A contaminant present in trace amounts is 2, 3, 7, 8-tetrachlorodibenzo-para-dioxin (TCDD or dioxin) which is one of the most toxic chemicals known to man.

Signs and Symptoms

Since the late 1940's at least 20 episodes of exposure to dioxin have occurred. The best documented industrial accident occurred in 1947 in Nitro, West Virginia, involving more than 100 individuals. A recently completed 30-year follow up has not revealed any association with early mortality in those exposed. Another incident involved a chemical plant in Sevesco, Italy, on July 10, 1976, in which 447 patients developed skin lesions attributable to dioxin exposure. Acute exposure symptoms are nausea and vomiting, headache, fever, burning and irritation of skin, impairments in senses of smell, taste and touch,

tremors and temporary focal paralysis. The long-term effects are poorly documented and potentially the most harmful. Chloracne is most often the first and most constant of the symptoms of the chronic type. Others include numbness and tingling of the extremities, liver dysfunction, loss of sex drive, radical mood changes and weaknesses.

The two most serious potential problems, however, are cancer and birth defects. In a study done by Toth, et al, mice with peroral exposure to dioxin over two years showed an increased frequency of hepatomas over the control group.¹ Another study on mice with peroral exposure to 2, 4, 5-T showed an increased tumor incidence in one of two strains.² In a case control study there was a six-fold increase in soft-tissue sarcomas in those exposed to phenoxyacetic acids or chlorophenols C.³ As to its teratogenicity, Courtney, et al, reported an increase in mortality, gastrointestinal hemorrhage and cystic kidneys in rat fetuses from females treated with 2, 4, 5-T containing approximately 30 ppm dioxin.⁴ These findings have been verified in similar study by Sparschu, et al.⁵

Investigative Efforts

Definitive answers on whether or not Agent Orange is responsible for the aforementioned mental and physical problems must await more definitive studies. One of these presently underway by the Air Force is aimed at tracking down about 1,200 personnel involved in "Operation Ranch Hand." These individuals worked with loading and aerial spraying of Agent Orange over Vietnam. The study will include development of a questionnaire, physical examination, statistical evaluation, and follow-up of participants until at least 1986.

The Veterans Administration has established an Agent Orange registry for any Vietnam veteran expressing a concern relating to exposure to herbicides. The registry includes a thorough history, physical examination and follow-up for a period of several years to determine long-term health effects from herbicide exposure.

The Authors

FRANKLIN P. FLOWERS, M.D., AND NEIL A. FENSKE, M.D.

Dr. Flowers is Assistant Professor of Medicine, Division of Dermatology, and Dr. Fenske is Assistant Professor of Medicine and Director, Division of Dermatology, University of South Florida College of Medicine, Tampa.

PATTYE A. WHISMAN, M.D.

Dr. Whisman is associated with St. Anthony's Hospital at Columbus, Ohio.

In a separate study, the Veterans Administration is comparing adipose tissue removed in the course of various surgical procedures on veterans with documented exposure to the herbicides with samples removed from former servicemen who were not in Vietnam. Dioxin appears to be preferentially stored in adipose tissue and may be released into the system when an individual loses weight, as DDT is known to do.

The Interagency Work Group to Study Possible Long-Term Health Effects of Phenoxy Herbicides and Contaminants was recently established to coordinate studies as well as eliminate bias in studies conducted by the military. The group consists of representatives from the National Toxicology Program, National Institute of Environmental Health Sciences, Occupational Safety and Health Administration, U.S. Department of Health and Human Resources, Veterans Administration and others.

Recently the Veterans Administration awarded \$144,000 to the University of California at Los Angeles to design a study on the effect of human exposure to Agent Orange. This epidemiological study will be evaluated by the Interagency Work Group to Study the Possible Long-Term Health Effects of Phenoxy Herbicides and Contaminants.

Conclusion

The impact of Agent Orange on soldiers and civilians may not be appreciated for ten to 20 years because, like cigarette smoking and arsenic ingestion, the malignancies may take that long to manifest themselves. The studies underway are the beginning of an effort to sort out the effects of this herbicide on our health and reproduction. It will take the combined efforts of physicians, scientists, and government to evaluate its deleterious effects and, hopefully, prevent the possibilities of tragedies, such as this, from happening again.

References

1. Toth, K.; Sugar, J.; Somfai-Relle, S., and Bence, J.: Carcinogenic Bioassay of the Herbicide 2, 4, 5-trichlorophenoxy-ethanol (TCPE) with Different 2, 3, 7, 8-tetrachlorodibenzo-p-dioxin (dioxin) Content in Swiss Mice, *Prog. Biochem. Pharmacol.* 14:82, 1978.
2. Muranyi-Kovacs, I.; Rudali, G., and Imbert, J.: Bioassay of 2, 4, 5-trichlorophenoxyacetic Acid for Carcinogenicity in Mice, *Brit. J. Cancer* 33:626, 1976.
3. Hardell, L., and Sandstrom, A.: Case-Control Study: Soft-Tissue Sarcomas and Exposure to Phenoxyacetic Acids or Chlorophenols, *Brit. J. Cancer* 39:711, 1979.
4. Courtney, K. D.; Gaylor, D. W.; Hogan, M. D.; Falk, H. L.; Bates, R. R., and Mitchell, I.: Teratogenic Evaluation of 2, 4, 5-T, *Science* 168:864, 1970.
5. Sparchu, G. L.; Dunn, F. L., and Rowe, V. K.: Study of Teratogenicity of 2, 3, 7, 8-tetrachlorodibenzo-p-dioxin in Rat, *Fd. Cosmet. Toxicol.* 9:405, 1971.

- Dr. Flowers, USF College of Medicine, Box 19, 12901 N. 30th Street, Tampa 33612.

Prayer for Physicians

*Father, we deal with people in tender times and
in tough times.*

*Sometimes we tend to think that we can do any-
thing. when we really can't.*

*Give us the grace to understand that even we need
a hand to hold, a friend who will listen*

When we too are fighting tigers in the dark. Amen.

Chaplain Powers McLeod

Editor's note: Chaplain McLeod offered this prayer at a recent meeting of the Escambia County Medical Society.

NOTES AND NEWS

Dr. James T. Howell Gets High Level State Post



Dr. Howell

James T. Howell, M.D., a 41-year-old public health specialist, has been appointed to the highest post in state government held by a physician in more than a decade.

Dr. Howell's appointment as Deputy Secretary of the Florida Department of Health and Rehabilitative Services was announced in November by Secretary David Pingree. For the past two years, Dr. Howell had

served as State Health Officer and Staff Director of the Health Program Office, a part of the Department of HRS.

Secretary Pingree himself recently returned to HRS for a second term at the helm after serving for several months as a top assistant to Gov. Bob Graham.

Not since prior to governmental reorganization in 1969 has a Florida physician held such a high position in state government. The 1969 reorganization transformed the old State Health Officer-State Board of Health System into a Division of Health within the Department of Health and Rehabilitative Services.

The first Director of the Division of Health was Wilson T. Sowder, M.D., who had served for many years with the old State Board of Health as State Health Officer. In the 1970's, the legislators reorganized HRS itself, de-commissioning all the operating divisions, including the Division of Health.

From that day to the present, Florida's public health program has been administered through the "Health Program Office."

The new No. 2 man in HRS was born in New York City, and received his M.D. degree from New York Medical College in 1966. Six years later, he took a Master of Public Health Degree at Harvard School of Public Health. That same year he arrived in Florida as Assistant Director of the Palm Beach County Health Department, a position he held until 1977.

Prior to becoming State Health Officer in July of 1979, Dr. Howell was Health Program Supervisor of HRS District IX.

A Diplomate of the American Board of Preventive Medicine, Dr. Howell has been active in many professional groups including the Florida Association of County Health officers, the Florida Medical Association, the Palm Beach County Medical Society and the Florida Society for Preventive Medicine.

Dr. Howell and his wife, Catherine, are the parents of two boys, David, 15, and James, 11.

Insurance Reciprocal Announces 17.5% Premium Rate Increase

A 17.5 percent increase in premium rates for 1982 has been announced by the Florida Physicians' Insurance Reciprocal (FPIR).

In making the announcement, FPIR observed that there have been two dividends and only one other premium increase since the first policies were marketed six years ago. Physicians in Dade and Broward counties will continue to pay 45 percent more than the rest of the state.

Physicians in four specialties will be increased more than 17.5 percent because they are being raised to higher classifications in the five-class rating system. Effective January 1, neurologists, pediatricians and radiologists are moving from Class 1 to Class 2. Emergency medicine physicians, formerly in Class 2 with a 50% surcharge, are being reclassified as Class 3. In recent years, losses suffered by these four specialties have exceeded premiums substantially, according to FPIR.

The Reciprocal stated it is in sound financial condition but the number of claims and severity of claims has more than doubled in six years.

"Our reinsurers (Lloyd's of London and others) are still solidly behind us, and our treaty has been finalized for 1982," FPIR said. "They observe another serious crisis coming in America, but believe our Reciprocal can weather the storm if we are prudent and plan ahead and charge adequate premiums to remain solvent."

1982 Issues Previewed At Legislative Workshop

Congressional redistricting, legislative reapportionment and sunset review of some important laws promise to set a hectic and grueling pace for the 1982 Florida Legislature.

This basic message was conveyed by many of the speakers at the 1982 Florida Medical Association Legislative Workshop in Tampa on October 24.

Opening the one-day conference, FMA President Sanford A. Mullen, M.D., of Jacksonville, emphasized the importance of organized medicine's involvement in the governmental process. "We must participate to keep the uninformed from regulating us out of business," he admonished some 130 key contact physicians, FMA officials and others interested in the legislative process.

The keynoter, State Rep. Beverly B. Burnsed of Lakeland, said she does not expect much significant action on issues during the 1982 Legislature until the reapportionment issue is disposed of. Additional money for programs will be scarce, although she believes that action by Florida's pediatricians may result in some additional funds for children's medical services.

Ms. Burnsed is Chairman of the House Committee on Health and Rehabilitative Services.

Insurance and Hospital Codes

FMA is vitally interested in the sunset review of the state insurance code and the hospital licensure law.

The insurance code includes such matters as the Patient's Compensation Fund, mandated insurance coverage, HMO regulation, standard health claim form, reciprocal insurers, etc. State Rep. Tom Gustafson of Fort Lauderdale, Chairman of the House Insurance Committee, advised the conference that a proposed revised code, running about 1,500 pages, will be available in printed form by the first of the year.

Louis C. Murray, M.D., of Orlando, Chairman of the FMA Council on Legislation, unveiled FMA's 1982 legislative program. He said priorities would include opposition to the use of prescription drugs by optometrists, state funds for HSA's, and hospital staff privileges for chiropractors. Legislation to require filing of written protocols with the State Board of Medical Examiners and appropriate supervision of Advanced Registered Nurse Practitioners will be among those items receiving FMA's support.

"The program we have here today for 1982 is no good just on paper," Dr. Murray concluded. "We have to go out and see that it is implemented."



Two prominent members of the Florida Legislature were among speakers at FMA's 1982 Legislative Workshop in Tampa. In photo at left, State Rep. Beverly Burnsed of Lakeland keynotes the conference as FMA President Sanford A. Mullen, M.D., (left) and Louis C. Murray, M.D., Chairman of the Council on Legislation listen. In right photo, State Sen. David H. McClain of Tampa speaks. At his left is another speaker, State Rep. Tom Gustafson of Fort Lauderdale.

Professional Liability

State Sen. David H. McClain of Tampa discussed the matter of professional liability in his remarks to the group. "As long as you can't perform miracles, you are going to be sued," Senator McClain warned the doctors.

He counselled the doctors to take an interest in the election of judges "because you are going to see more suits and we are going to have to re-address the mediation issue." He was referring to an FMA-sponsored law of the 1970's establishing pre-trial mediation procedures, which ultimately was struck down by the Florida Supreme Court.

He advised the FMA to "improve your contact physicians, raise a war chest, help your friends and kick Hell out of your enemies."

Discussion turned from state and federal matters at lunch, at which the speaker was U.S. Rep. Andy Ireland of Florida's 8th Congressional District.

Mr. Ireland predicted that Florida's rapid population growth as reflected in the 1980 census will mean more federal dollars for health programs in the State. He also expressed the opinion that the current federal administration and the Congress will ease up on regulation of professionals and business.



U.S. Rep. Andy Ireland of Florida's 8th Congressional District speaks on federal legislative issues in an after-luncheon address at the FMA Legislative Workshop.

Dr. Ralph Jack Honored by the Papanicolaou Institute

Dr. Ralph W. Jack, Chairman of the Board of the Papanicolaou Cancer Research Institute for the past eleven years and a prominent Greater Miami obstetrician and gynecologist for half a century, was honored at a buffet reception given by the Institute on November 6.

President of the Florida Medical Association in 1959, Dr. Jack served two terms as president of the Dade County Medical Association, and is a former vice president of the American College of Obstetricians and Gynecologists. A graduate of Yale University, he received his medical degree from John Hopkins Medical School in 1930.

For some 25 years Dr. Jack has worked to help the Papanicolaou Center become one of the nation's leading institutions for basic cancer research.

Dr. and Mrs. Jack will be leaving the Miami area to make their home with a son in Corpus Christi, Texas.

American Heart Association Elects Miami Physician

Mary Jane Jesse, M.D., of Miami, has been named President-elect of the American Heart Association.

Dr. Jesse, Vice Chairman of the Department of Pediatrics at the University of Miami School of Medicine, was elevated to the position at the AHA Annual Assembly in Dallas on November 15. AHA has a membership of about 40,000 physicians and 80,000 laymen.

A native of Owensboro, Ky., Dr. Jesse received her medical degree from the Columbia College of Physicians and Surgeons in 1959. She joined the University of Miami faculty in 1970 and three years later was named Berenson Professor of Pediatric Cardiology and Director of the Division of Pediatric Cardiology.

New Center for Health Policy Research Approved

The Florida Board of Regents has approved the establishment of a Center for Health Policy Research at the University of Florida.

The Center will coordinate research into health policy issues such as the supply and requirements for health manpower in Florida and the effectiveness and costs of various approaches both to therapy for diseases and for health maintenance.

Dr. Kerry E. Kilpatrick, Ph.D., director of the Health Systems Research Division at UF's Health Center, has been appointed Director of this new center.

Family Practice Program Integrates Aging Theme

The Florida Academy of Family Physicians will conduct its own program on aging during the 108th Annual Meeting of the Florida Medical Association.

"The Process of Aging" is the over-all theme for the scientific session of the meeting, to be conducted at the Diplomat Hotel in Hollywood, May 5-9, 1982. The Section on Family Practice, on Saturday, May 8, will address the subject of angina, psychiatric problems, skin problems and physical fitness in the aging and elderly.

All physicians registered for the convention are invited to attend the Family Practice Section as well as all other scientific sessions that are part of the Annual Meeting scientific program.

Meanwhile, the Florida Medical Foundation Committee on Impaired Physicians announced it would sponsor a Section on Chemical Dependency for the second consecutive year. The featured speaker will be John-Henry Pfifferling, Ph.D., a medical anthropologist from Chapel Hill, N.C.

The following scientific sections have been announced and completed in addition to those reported in the November issue of *The Journal*.

FRIDAY MORNING, MAY 7

SECTION ON CHEMICAL DEPENDENCY

(Co-sponsored by Florida Medical Foundation
Committee on Impaired Physicians)

Friday, May 7 — 8:00 a.m. to 10:45 a.m.

John C. Eustace, M.D., Miami

Program Chairman

Welcome — Guy T. Selander, M.D., Chairman, Committee on Impaired Physicians, Jacksonville; and Dolores A. Morgan, M.D., Medical Director, FMA/FMF Impaired Physician Program, Miami.

"Prevention of Impairment in the Professional" — John-Henry Pfifferling, Ph.D., Medical Anthropologist and Founder, Center for the Well-Being of Health Professionals, Chapel Hill, N.C.

"Dealing with Practice Stressors" — John-Henry Pfifferling, Ph.D., Chapel Hill, N.C.

"Preventing Partnership Divorce" — John-Henry Pfifferling, Ph.D., Chapel Hill, N.C.

SECTION ON EMERGENCY MEDICINE

(Co-sponsored by Florida Chapter,
American College of Emergency Physicians)

Friday, May 7 — 8:00 a.m. to 10:45 a.m.

Martin Arostegui, M.D., Miami

Program Chairman

"Critical Care Medicine in a Private Hospital Setting" — Martin Arostegui, M.D., Miami.

"Advanced Cardiac Life Support — Review" — Jeffrey Bettinger, M.D., Miami.

"Advanced Trauma Life Support — Review" — Eugene L. Gitin, M.D., Miami.

FRIDAY AFTERNOON, MAY 7

SECTION ON RADIOLOGY

(SECTION I)

(Co-sponsored by Florida Radiological Society)

Friday, May 7 — 1:50 p.m. to 5:00 p.m.

Noel R. Zuzmer, M.D., Miami Beach

Program Chairman

Welcome — Robert J. Mandel, M.D., President, Florida Radiological Society, Melbourne.

"Clinical Aspects of Digital Radiography" — Jerome Sheldon, M.D., Associate Professor of Radiology, University of Miami School of Medicine, Miami.

"Future of N.M.R. Imaging" — John Goddard, Ph.D., Adjunct Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

"Interventional Radiography" — Sheldon Roen, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

SATURDAY MORNING, MAY 8

SECTION ON OCCUPATIONAL MEDICINE

(Co-sponsored by Florida Occupational
Medical Association)

Saturday, May 8 — 8:00 a.m. to 11:45 a.m.

F. Layton Bergquist, M.D., Lakeland

Program Chairman

"Occupational Accidents and Their Impact on the Occupational World"

Welcome — F. Layton Bergquist, M.D., Program Chairman, Lakeland.

"Occupational Accidents That Require Major Surgical Intervention" — Anand Rao, M.D., Private Surgeon, Lakeland.

"Psychological Effects on Accident Victims" — Maurie Pressman, M.D., Department of Psychiatry, Horizon Hospital, Clearwater.

"The Accident, The Worker and The Employer" — F. Layton Bergquist, M.D., Clinical Assistant Professor of Comprehensive Medicine, University of South Florida College of Medicine, Lakeland.

SECTION ON PEDIATRIC SURGERY

(Co-sponsored by Florida Association of Pediatric Surgeons)

Saturday, May 8 — 9:00 a.m. to 12:00 noon

Ronald F. David, M.D., Orlando

Program Chairman

Introduction and Welcome — Ronald F. David, M.D., President, Florida Association of Pediatric Surgeons, Orlando.

"Protection of the Solitary Testes" — H. Warner, Webb, M.D., Peter Stevens, M.D., and Albert Wilkinson, M.D., Jacksonville.

"Primary Resection Without Diversion for Necrotizing Enterocolitis" — Ralph Swank, M.D., Tampa.

"Successful Management of Malignant Hyperthermia" — John Krause, M.D., Jacksonville.

"Congenital Evisceration" — William Richardson, M.D., Tampa.

"Ureteropelvic Junction Obstruction in the Newborn" — Charles Lankau, M.D., and Malvin Weinberger, M.D., Miami.

"The Remarkable Dr. Roget" — Hugh Lynn, M.D., Director of Undergraduate Education and Surgery, University of Alabama School of Medicine, Birmingham, Ala.

SECTION ON FAMILY PRACTICE

(Co-sponsored by Florida Academy of Family Physicians)

Saturday, May 8 — 9:00 a.m. to 12:00 noon

Bernard Breiter, M.D., Daytona Beach

Program Chairman

"Expanded Concept of Angina in the Aging — Role of Calcium Antagonists" — Alan B. Miller, M.D., Chief of Cardiology, JHEP Department of Medicine, University Hospital, Jacksonville.

"Psychiatric Problems of Elderly Patients in Family Practice" — Fred B. Charatan, M.D., Chief of Psychiatry, Jewish Institute for Geriatric Care, Long Island Jewish — Hillside Medical Center, New Hyde Park, N.Y.

"Physiological Changes in Cutaneous Aging" — Neil Fenske, M.D., Associate Professor and Director, Division of Dermatology, University of South Florida College of Medicine, and Chief, Division of Dermatology, Veterans Administration Hospital, Tampa.

"Physical Fitness in the Elderly" — John Warren, M.D., Assistant Professor, Department of Family Medicine, University of South Florida College of Medicine, Tampa.

SECTION ON RADIOLOGY

(SECTION II)

(Co-sponsored by Florida Radiological Society)

Saturday, May 8 — 9:00 a.m. to 11:45 a.m.

Noel R. Zusmer, M.D., Miami Beach

Program Chairman

"Unusual Mammographic Presentations of Cancer" — Joel Schneider, M.D., Clinical Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

"Automated Sonography of the Breast" — Victor G. Maturo, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

"Pelvic Ultrasound" — Noel R. Zusmer, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

Applications Still Accepted For Scientific Exhibits

The FMA Committee on Medical Education is still accepting applications for scientific and educational exhibit booths at the 108th Annual Meeting of the Florida Medical Association.

Deadline for applications is January 1, 1982, according to Calvin W. Martin, M.D., of Arcadia, Chairman of the Subcommittee on Annual Meeting Scientific Program.

Dates for the Annual Meeting are May 5-9, 1982, at the Diplomat Hotel in Hollywood. Exhibits are to be set up on Wednesday afternoon, May 5, and will be available for viewing on Thursday, Friday and Saturday, May 6-8.

Exhibits will be judged, and first, second and third place and honorable mention ribbons will be awarded, Dr. Martin said.

Application forms may be obtained by contacting the Committee on Medical Education, Florida Medical Association, Attention: Mr. Edward D. Hagan, P.O. Box 2411, Jacksonville, Florida 32203.

Occupational Health Conference Conducted in Jacksonville

The 15th Florida Occupational Health Conference was conducted in Jacksonville, October 22-25, under the joint sponsorship of the Florida Occupational Medical Association (FOMA) and the Florida State Association of Occupational Health Nurses. As a tribute to attending nurses and physicians, the week of October 18-25 was proclaimed Occupational Health Week in Duval County.

Theme of the conference was "Occupational Health Managers on the Company Team."

James Harvey Rester, M.D., Gainesville, was installed as President of the FOMA, succeeding Francis L. Bergquist, M.D., of Lakeland. Charles E. Fitzgerald, M.D., Maitland, was named President-Elect.

Other new officers include Harold E. Engelbaugh, M.D., Indialantic, Vice President, and Nicholas G. Alexiou, M.D., Tampa, Secretary-Treasurer.

The 1982 Occupational Health Conference will be held at Palm Beach Shores, with specific dates to be announced later.

Dr. Charles P. Gibbs, Appointed to New Assistant Dean Post

Charles P. Gibbs, M.D., Professor of Anesthesiology and of Obstetrics and Gynecology at the University of Florida, has been appointed to the newly established position of Assistant Dean for Curriculum at the UF College of Medicine.

Dr. Gibbs has been involved with the college's curriculum committee in various capacities since 1974.

"Creativity" at Museum of Science in Miami

An exhibition commissioned by Chevron that has attracted more than four million visitors on its nationwide tour will be in Miami through February 7, 1982 at the Miami Museum of Science.

"Creativity — the Human Resource" features the work-in-progress of diverse creative Americans such as Jonas Salk, Linus Pauling, Jasper Johns and Margaret Mead.

The purpose of this exhibit is to feature the *process*, rather than the *products*, of human creativity by examining how these prominent American scientists and artists think and work.

The exhibit is open to the public, Monday through Wednesday from 10 a.m. — 6 p.m., Thursday through Saturday from 10 a.m. — 10 p.m.; and Sunday from 11 a.m. — 10 p.m. There is an admission charge to the Museum itself; the exhibit is free.

Southern Medical Association Observes 75th Annual Scientific Assembly

Congratulations to members of the Southern Medical Association on the occasion of their 75th Annual Scientific Assembly.

Scientific sessions in 21 specialties and 26 postgraduate courses were offered as a part of this "Diamond Jubilee" celebration held in New Orleans, November 15-18.

JCAH Survey Additions

Two additional hospitals will be surveyed by the Joint Commission on Accreditation of Hospitals (JCAH) during this fourth quarter.

The newest hospitals to be added to those surveyed are Town and Country Hospital, Tampa, and H. H. Raulerson Jr. Memorial Hospital, Okeechobee.

That brings to 24 the number of hospitals undergoing JCAH surveys this quarter.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Endoscopic Control of Gastrointestinal Hemorrhage, by John P. Papp, M.D., Editor. 194 Pages. Price \$64.95. CRC Press, Inc., Boca Raton, Florida, 1981.

The stated purpose of the book is to "present the state of the art on endoscopic control of gastrointestinal hemorrhage." The ten chapters review a general approach to the patient, electrosurgical principles, electrocoagulation and photocoagulation.

H. Worth Boyce Jr., M.D., of USF, Tampa, was the author of the chapter on the general approach to upper GI bleeding.

Jerome D. Waye, M.D., Mt. Sinai School of Medicine, wrote a concise chapter on the approach to the patient with rectal bleeding. B. H. Gerald Rogers, M.D., of Chicago, contributed the chapter on electrocoagulation of vascular abnormalities of the large bowel.

While most of the material presented here can be assembled from the literature, this book presents a concise summary of pertinent material. Appropriate references accompany each chapter. This book can be recommended for hospital and medical school libraries, especially where there is an active endoscopy unit.

F.N.V.

Books Received

Receipt of the following books is acknowledged.

Clinical Cardiology, 3rd edition, Maurice Sokolow and Malcolm B. McIlroy. 763 Pages. Price \$21.50. Illustrated. Lange Medical Publications, Los Altos, California, 1981.

Legal Rights of Asbestos Exposure Victims, Roman M. Silberfeld and Richard L. Hecht, authors and publishers. 14 Pages. Free. Los Angeles, California, 1980.

Lifelong Sexual Vigor: How to Avoid and Overcome Impotence, Marvin B. Brooks, M.D., FACS. 249 Pages. Price \$12.95. Doubleday and Company, Inc., New York, New York, 1981.

THE APPROPRIATE GIFT FOR AN INTERN OR RESIDENT

Give a year's subscription to the

Journal of the Florida Medical Association

CUT OUT AND MAIL TO:

FLORIDA MEDICAL ASSOCIATION

Post Office Box 2411

Jacksonville, Florida 32203

Please send my gift subscription to:

Dr. _____

Mr. _____

Ms. _____ Status: _____

Street _____

City & State _____

Send the bill for \$15.00 (add .60 sales tax if you live in Florida)

Dr. _____

Street _____

City & State _____



FMA AUXILIARY

Aging: A Positive Process

Since ancient times, dreamers have been looking for a mythical "Fountain of Youth." Unfortunately, they have searched in the wrong places. Instead of exploring the world, they should have looked within themselves.

Inside each of us is our personal "fountain of youth," that bubbling stream of tenacity and optimism which sustains us in the day to day problems of living.

We are all aging, each in a unique way. Some persons have a phobia about growing older; every wrinkle brings a twinge. Dressing tables are cluttered with creams, lotions, hair restorers, and beauty aids promising to hold back the years, even reverse the calendar.

Good grooming is desirable, but lavish attention to preparations of questionable value may be diverting our energies from activities which can help us age gracefully and productively. A life full of meaningful learning experiences allows little time for worry about aging; age is more a matter of outlook than chronology.

H. L. Harrell Sr., M.D., a Marion County physician and member of the Florida Council on Aging, says, "My elderly patients, many of whom are working for a pittance, are happier and healthier just for having a job. The idle retiree uses much more medical care than does even a partially employed one."

Let us not make the common mistake of categorizing the elderly and mentally putting them "on the shelf." For the most part, they are capable individuals with much to offer society; it is a crime to waste their expertise and wisdom acquired over a lifetime. We should make it a priority to help them back into the mainstream.

There are many ways to reach those who need help in dealing with the changes brought about by aging.

When indexing needs of the elderly, auxiliaries need to be aware of certain realities. Some aging persons are not receiving needed financial and moral support from their families. Often, physical disabilities are sloughed off as senility. This is a terrible injustice; senility is not nearly so common as believed. Suffocating boredom is more prevalent. The feeling of being useless and unneeded can be crushing.

Foster Grandparent programs can help by bringing together the young and the old. Children can gain from an older person who has time to tell a story or listen patiently to the little troubles and accomplishments that are often missed by busy parents. Contact with youngsters may be better than vitamins for the elderly.

The problem of older parent abuse is rising to proportions nearing those of child abuse. Elderly parents living with children are sometimes punished for unavoidable accidents or inconveniences by being deprived of meals, locked in their rooms, or even physically abused. Residents of nursing homes are sometimes completely ignored by their children.

In Florida, the Auxiliary is placing special emphasis on investigating the aging process. We are bringing our energies and talents to bear in addressing the needs of the elderly in our particular communities.

The time has passed when one can ignore the elderly. We must proceed without further delay to raise the quality of life for this group. 1981-82 is the year for self-education, sharing of knowledge, personal involvement, and data gathering to equip ourselves to contribute intelligently to programs designed to make later years the "golden years"!

*Mrs. Fred P. Swing
State Chairman
FMAA Committee on Aging
Charlotte Harbor*

WORTH REPEATING

Can Big Government and Medicine Ever Find Happiness Together?

There is a pervasive belief, deeply rooted in the American consciousness, that the Federal government is a big, bad bear. The notion of Big Government intruding into our private worlds has always been anathema to the national spirit. Monster, bureaucracy, red tape, boondoggle, and inefficiency are some of the stock words that we have in our arsenal to poke fun at Uncle Sam and, when the occasion demands, to kick his pants off. Among physicians, the distrust of Uncle Sam has always been of epidemic proportions, occasionally bordering on paranoia. Indeed, it has become a truism that everytime the Fed sneezes, the medical establishment catches a cold.

Physician antipathy to government intrusion, like that of the general public, is grounded in the national character. The spirit of free enterprise created modern America and it spawned the Golden Age of Medicine. Who is Uncle Sam to tell American physicians what to do? In 1980, at a time when the medical profession perceived government interference in Medicine as being too unwieldy, it was not surprising that physicians, almost to a man, voted for Ronald Reagan, who had promised less government, and then breathed a sign of collective relief when he won.

Traditionally, the relationship between the Federal government and the medical establishment was a pretty much casual affair, and it was a happy one. Physicians, usually through the AMA, made sure that the other party did not make any serious advances. But one day the flirtation stopped. A dramatic change emerged in the mid-sixties when the idea of the Great Society took shape. This was a time of big upheavals and changes; Medicine, at the time, got caught in the grip to accommodate these changes. Social planners who espoused the philosophy that health care is a right started tinkering with the medical machine and discovered some defects. Access to health care, for one thing, was found wanting in certain groups. Amidst staunch opposition from the medical profession, Medicare was born. Medicaid followed a few years later.

But federal involvement with Medicine did not end with Medicare and Medicaid. Washington poured money to build more hospitals across the country, to enlarge existing medical schools and create new ones, to form a system of VA and Public Health hospitals, and to generate research through the massive National Institute of Health. It was a blitz that even the durable medical establishment did not quite anticipate.

For physicians it was a boon and a bane. Medicare and Medicaid money meant increased incomes; more physicians spelled relief from tremendous workloads and offered more time for family and pleasure; and advances in research made medical practice more promising. The trade-offs spinning from creeping Federalism into Medicine, however, are what frighten physicians. The 70's offer a classic example of this growing monster and a few ugly heads that have sprouted off the top. Let us name a few: PSRO's, HSA's, mandatory continuing medical education, threats of periodic licensure examinations, and the ever looming specter of a national health insurance system even when this has been a spectacular failure in other countries.

Physicians are not against the concepts espoused by the government in promoting good medical care, in making this care available to all Americans, and in controlling medical costs. But they object to the excessive costs involved in these projects, to the massive layers of bureaucracy along with the ineptness and red tape, to the maze of contradictory rules and regulations with their paralyzing effect on the medical system, to the duplication of efforts already being done efficiently and economically by the private medical sector, and, perhaps most important, to the threats on the freedom of physicians to practice good medicine.

As much as physicians desire minimal interference from the government, the reality is that Uncle Sam will continue to be involved in the administration of health care in some fashion or another; it has too much financial stakes not to do so. Health care spending in 1980 totalled

nine to ten percent of the gross national product; of this amount, the government financed approximately 40%. With the costs of medical care continuing to escalate, it is not unreasonable to expect an increase in government spending.

Against this reality, the medical profession should be prepared to enter into a relationship that should serve the common goals of both parties and yet preserve the best features of our medical system and assure the independence of physicians in an atmosphere of free enterprise. Uncle Sam, even with his money and power, should withdraw from the stance that he can bully the medical profession to submit meekly to his high edicts fashioned by bureaucrats from Washington. The examples of Great Britain and Canada, where the government has decided to run the medical system, should serve as painful reminders of this arrogance. Physicians, on the other hand, should back away from their paranoia of the government. They should stop being merely passive spectators and reacting at and complaining about everything

but should take the initiative to recognize the issues and the problems and to seek solutions to them, never for their interests, but for the patients. There is no way the government can poke its nose without being snipped as long as physicians do their job well.

A marriage between Big Government and the medical profession is probably not possible; nevertheless, it should be possible to arrange a co-existence of mutual accommodation to carry out a common cause. They may even live happily ever after.

*R. G. Lacsamana, M.D.
Daytona Beach*

Reprinted from: *The Stethoscope, Bulletin of the Volusia County Medical Society, June 1981.*

RVS, Specialty Screens, PATCO and Medicine

A new Florida Relative Value Study (RVS) is being considered by appropriate FMA commissions and committees. I wonder how many of us are familiar with the old one of 1975?

In family practice there are five codes for a new patient and seven for an established patient. The unit value on these codes runs from 8.1 to 14.1, with a "by report" thrown in for good measure. For the established patient the unit value runs from 4.0 (minimal service, for example, an injection) to 10 (comprehensive re-examination complicated by a chronically disabling condition).

If most of you are in the same boat as I, you probably never use more than two to four of these thirteen codes. It is difficult for me to understand how a "comprehensive re-examination" (Code #90058) can be worth two times that of a "limited examination, evaluation, and/or treatment, same or new illness" (Code #50050). This, I would think, would translate into the usual, routine office call with a unit value of 4.8. If we accept 4.8 as a routine office call and assign a fee value of \$20 to \$25, then the value of the comprehensive re-examination becomes \$50 to \$60. Further, a comprehensive history and exam on a new

patient (Code #90020) has a unit value of 14.1 or approximately \$75 to \$85. I would hasten to point out that these fees do not include any lab or X-ray charges! For hospital patients the unit values are, of course, higher: 20.2 for initial care with a comprehensive history and exam, and 6.1 to 6.6 units for follow-up care, and a special code and unit value for discharge at 8.8 or approximately \$40 to \$50.

I must point out that these figures depend on what dollar value (conversion factor) the individual physician places on his individual unit. I arrived at these figures by assuming a unit value of \$3.50. At any rate, if we were to try to follow these schedules and codes, I am afraid it would increase fees considerably. After considerable deliberation I personally do not feel so many codes are needed!

Recently I was conversing with a good friend who is a sub-specialist in one of the medical disciplines. This doctor was concerned about third party reimbursement being based on a RVS code alone, without regard to the additional time and cognitive skills involved in his initial examination. I know how much time this physician

spends with his work-ups, and I agree that he should be compensated accordingly. The problem, then, is how to do this in an equitable fashion. It is here that I feel RVS codes are beneficial. With the proper codes and modifiers, any physician should be able to be reimbursed properly.

There is continuing struggle within medicine and outside of medicine regarding the relationship between fees for cognitive skills as opposed to fees for technical skills (manipulative and/or surgical procedures). There seems to be a disproportionate reward between a 15-minute office call for \$20 and a half-hour anesthesia or surgical bill for hundreds of dollars. Perhaps these disparities are legitimate. I do not choose an adversary position at this time, but I will attest that more than 90% of complaints regarding fees are directed at procedural fees, i.e., surgical, anesthesia or endoscopy.

In the July 2 edition of *The New England Journal of Medicine*, Vol. 305, No. 1, there is an excellent article on "The UCR Boondoggle, a Death Knell for Private Practice." I recommend this article to all physicians. This article points out that the surgical operation which heads the list in dollar cost is, quite expectedly, the coronary bypass. In 1979, all the coronary bypass operations were performed by 700 surgeons. This divides up to an average workload of less than three cases per week per surgeon at an annual income of \$350,000.00 from this procedure alone (and assuming a \$2,500.00 average fee, which is below average today).

In another article which appeared in *Medical Economics* of July 9, 1979, our own Guy Selander, M.D., points out that primary physicians can also be guilty of "over-charging," or in most cases, of "over-utilizing." The end result is the same increasing cost of medical care. It is up to all of us to attempt to control costs.

If we have a consultant about whom we hear frequent complaints, we should discuss this with him. The consultant also should discuss any complaints he may receive regarding the referring physician. Only with a concerted effort by all of us will medical costs be controlled.

Lastly, I would like to discuss PATCO! So much for PATCO! Certainly, this recent strike-fiasco should bring one point home to organized medicine. Medicine may need a union. It may need to negotiate at some future date. But, it certainly does not need to strike! I can think of no single act which would do more to subvert the cause of private medicine than a strike! Most Americans knew little if anything about air traffic controllers prior to their recent publicity. I, for one, would have estimated their salaries at considerably less than they were receiving, to say nothing of their strike demands! If the public has little sympathy for PATCO, you can imagine what empathy the public would have for physicians!

Arthur L. Eberly Jr., M.D.

President

Florida Academy of Family Physicians
Lighthouse Point

Reprinted from: Florida Family Physician, Fall 1981



Correspondence

IN PRAISE OF FAMILY MEDICINE

(The following letter was sent to the author of an article which appeared in the October issue of *The Journal* regarding rotating internships. The author, Richard A. DeRemee, M.D., is a board-certified specialist in pulmonary diseases with the Division of Thoracic Diseases and Internal Medicine at the Mayo Clinic in Rochester, Minn.).

Dear Dr. DeRemee: I read with great interest your article "What Became of the Rotating Internship?", which was reprinted in the October issue of *The Journal of the Florida Medical Association*, (Vol. 68, No. 10, pages 837-838).

I was interested on two counts. I agree that all specialists should serve one year of rotating internship, as I also did. However, in answer to your question as to who will care for the whole patient, because medicine cannot be fragmented with respect to the individual patient, I call your attention to the relatively new specialty of Family Medicine.

Family Medicine trains physicians to fill just that void that you are concerned about. There are presently over 6,000 Residents in Family Practice programs numbering over 350 in the U.S. I would refer you to the November 1979 issue of *The Journal of the Florida Medical Association* (Vol. 66, No. 11). This special issue outlines in detail the principles of Family Practice.

Family Physicians at the present time provide the continuity of care in dealing with the whole patient — referring to another specialist(s) when necessary — but at the same time maintaining contact and coordination of the patient's total health care needs.

The second count that interested me was your analogy of the rotating internship to passenger trains in which you state that many now wish for the return of this mode of transportation. I offer to you that they have never left the scene — fewer in number — yes) but they are still here in all their glory. I am referring to Amtrak, the nation's rail passenger service. Amtrak now provides the best rail passenger service we have seen in a decade, on long and short distance routes, with all brand new or refurbished equipment, with sleeping car and dining car service, from coast to coast.

So things are not as bad as your article intimates. We have a much better replacement for the rotating intern — the Family Physician; and the passenger trains are still rolling across our nation; although we could use many more, for the energy considerations you pointed out.

Charles A. Dunn, M.D.
FAAFP
Miami

MEETINGS

Accepted by the FMA Committee on Medical Education for Mandatory Credit

JANUARY

Classification, Clinical Court and Immunology of Malignant Lymphomas, Jan. 5, Fort Lauderdale. For information: John Fichtelman, M.D., P.O. Box 23460, Fort Lauderdale 33307.

Arthroscopic Update Emphasizing Problem-Solving in Therapeutic Arthroscopy of the Knee, Jan. 10-14, Sandpiper Bay, Port St. Lucie. For information: Ronald S. Grober, M.D., 2000 Nebraska Avenue, Ft. Pierce 33450.

Conferences in General Medicine and Family Practice, Jan. 11, International Hospital, Miami. For information: Lynn P. Carmichael, M.D., Department of Family Medicine, University of Miami School of Medicine, Miami 33101.

5th Annual Oral Pathology Review, Jan. 11-15, Miami. For information: Gloria Allington, Dept. of CME, P.O. Box 016960, Miami 33101.

Family Practice Grand Rounds, Jan. 13,27, Jacksonville. For information: Mary B. Kellogg, M.D., 655 W. 8th St., Jacksonville 32209.

Update 1982 — Management of Asthma and COPD, Jan. 14-16, St. Petersburg. For information: Dale E. Braddy, 911 Busse Highway, Park Ridge, Ill. 60068.

27th Annual Cardiovascular Seminar, Jan. 15-16, Holiday Inn Surfside, Clearwater Beach. For information: Mr. E. Jerry Eatman, American Heart Association, P.O. Box 7188, St. Petersburg 33734.

Continuing Education in Pediatrics — 1982, Jan. 17-21, Hollywood, Fla. For information: D.H. Altman, M.D., 6125 S.W. 31st St., Miami 33155.

Rx for a Healthy Heart, Jan. 18-21, Clearwater Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

Radiology for the Non-Radiologist, Jan. 18-22, Innisbrook, Fla. For information: Edward A. Eikman, M.D., 3100 East Fletcher Ave., Tampa 33612.

Clinical Immunology: Update for the Practitioner, Jan. 20-23, Lake Buena Vista, Fla. For information: JHM Health Center, Box J-233, Gainesville 32610.

Eighteenth Annual Cardiology Seminar, Jan. 21-22, Cedars of Lebanon Health Care Center, Miami. For information: Debbie Zayas, 1400 N.W. 12th Ave., Miami 33136.

Fourth Annual Walt Disney World Pulmonary Wintercourse, Jan. 21-24, Lake Buena Vista, Fla. For information: Asher Marks, M.D., 5526 Arlington Rd., Jacksonville 32239.

Round Table Day, Jan. 22, Hollywood, Fla. For information: Donald F. Altman, M.D., 6125 S.W. 31st St., Miami 33155.

Principles of Practice Management, Jan. 23-30, Vail, Colorado. For information: Sonja Auxier, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101.

Symposium on Intensive Care, Jan. 23-31, Vail, Colorado. For information: Sonja Auxier, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101.

7th Annual Review and Recent Practical Advances in Pathology, Jan. 25-29, Bal Harbour. For information: Dr. Sharon Thomsen, Dept. of Pathology, P.O. Box 016960, Miami 33101.

The Clinical Approach to Exercise Testing, Jan. 28-30, Orlando. For information: Ms. Betty Pac, P.O. Box 4835, Tampa 33677.

8th Annual Vail Conference in Anesthesiology, Jan. 30-Feb. 5, Vail, Colorado. For information: Sonja Auxier, Dept. of Anesthesiology, P.O. Box 016960, Miami 33101.

9th Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 31-Feb. 4, Bal Harbour, Fla. For information: Jose Strauss, M.D., Div. of Pediatric Nephrology, University of Miami, Miami 33101.

FEBRUARY

Florida Midwinter Seminar, Ophthalmology and Otolaryngology, Feb. 1-6, Fort Lauderdale. For information: Gaby Kressly, 405 N.E. 144 St., Miami 33161.

Sixteenth Annual Symposium on Cosmetic Surgery, Feb. 4-6, Cedars of Lebanon Health Care Center, Miami. For information: Debbie Zayas, 1400 N.W. 12th Ave., Miami 33136.

Third Annual Conference in Gastroenterology, Feb. 4-7, Lake Buena Vista, Florida. For information: S.N. Tewari, M.D., 1111 Kentucky Ave., Winter Park, Florida 32789.

Second Symposium on Burn Care, Feb. 5-6, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

Alert and
functioning
in the
sunset
years

Treat the symptoms in
the geriatric patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule
contains:

Pentylenetetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Breast Cancer Conference, Feb. 5-6, St. Joseph's Hospital, Tampa. For information: Ralph Jensen, M.D., P.O. Box 4227, Tampa 33677.

Conference in General Medicine and Family Practice, Feb. 8, International Hospital, Miami. For information: Lynn P. Carmichael, M.D., Department of Family Medicine, University of Miami School of Medicine, Miami 33101.

Family Practice Grand Rounds, Feb. 10, 24, Jacksonville. For information: Mary P. Kellogg, M.D., 655 W. 8th St., Jacksonville 32209.

Basic Mechanisms and Clinical Applications of Calcium Antagonists, Feb. 11, Miami. For information: Paul S. Swaye, M.D., 4701 N. Meridian Ave., Miami Beach 33140.

Calcium Antagonists, Feb. 16, Fort Lauderdale. For information: Jon R. Fichtelman, M.D., Holy Cross Hospital, Fort Lauderdale 33307.

Medical Update — 1982, Feb. 17-19, South Miami. For information: Leonard Zwerling, M.D., 7400 S.W. 62nd Ave., South Miami 33143.

Fourth Annual Oncology Update, Feb. 19-20, Cedars of Lebanon Health Care Center, Miami. For information: Debbie Zayas, 1400 N.W. 12th Ave., Miami 33136.

Third Annual Family Practice Update, Feb. 15-20, Daytona Beach. For information: Richard W. Dodd, M.D., Halifax Hospital, Daytona Beach 32015.

The Professional and Chemical Dependency — Challenge for the 80's, Feb. 18-21, West Palm Beach. For information: Ronald J. Catanzaro, M.D., Palm Beach Institute Foundation, West Palm Beach 33405.

The Pulmonary Cripple, Feb. 20-21, Melbourne, Fla. For information: George H. Mix, M.D. and J. L. Weare, M.D., 1304 S. Oak St., Melbourne 32901.

Clinical Management of Coronary Disease and Exercise Testing, Feb. 19-21, Fort Lauderdale. For information: Charles E. Aucremann, M.D., 7300 Demens Dr., South, St. Petersburg 33712.


Intensive Care for Neurological Disease and Trauma, Feb. 24-28, Miami Beach. For information: Div. of Continuing Education D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

Ninth Annual Selected Topics in Urology, Feb. 25-27, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

Midwinter Seminar in Obstetrics and Gynecology, Feb. 25-27, St. Petersburg. For information: James M. Ingram, M.D., University of South Florida College of Medicine, Tampa 33612.

Ninth Annual Pediatric Dermatology Seminar, Feb. 25-28, Miami. For information: Guinter Kahn, M.D., 16800 N.W. 2nd Ave., Miami 33169.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC. 
2500 West Sixth Street, Los Angeles, California 90057

Tampa Bay Winter Cardiovascular Seminar, Feb. 26-27, Tampa. For information: American Heart Association, P.O. Box 4835, Tampa 33677.

Traditional and Modern Chinese Acupuncture, Feb. 27-28, Lake Buena Vista, Fla. For information: Joseph Buben, 50 Maple Place, Manhasset, N.Y. 11030.

Spinal Cord Injury, Feb. 28-Mar. 4, Walt Disney World, Orlando. For information: William Brown, M.D., P.O. Box 016960, Miami 33101.

MARCH

Basic Neurology for Psychiatrists and Generalists: A Comprehensive Review Course, Mar. 1-5, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Postgraduate Medical Refresher Course, Mar. 1-12, Fort Lauderdale. For information: Charles E. Aucremann, M.D., 7300 Demens Dr. South, St. Petersburg 33712.

Current Clinical Concepts in Otolaryngology 1982, Mar. 3-4, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Comprehensive Review in Toxicology, Mar. 4-6, Orlando. For information: Charles E. Aucremann, M.D., 7300 Demens Dr. South, St. Petersburg 33712.

Pan American Symposium on Cancer of the Head and Neck, Mar. 5-6, Miami. For information: University of Miami School of Medicine, Dept. of CME, P.O. Box 016960, Miami 33101.

Internal Medicine, 1982, Mar. 7-12, Miami Beach. For information: J. S. Bocles, M.D., P.O. Box 016960, Miami 33101.

17th Annual Postgraduate Course in Internal Medicine, Mar. 7-12, Bal Harbour, Fla. For information: J. S. Bocles, M.D., P.O. Box 016960, Miami 33101.

14th Annual Teaching Conference in Clinical Cardiology, Mar. 10-13, Bal Harbour, Fla. For information: Michael Gordon, M.D., P.O. Box 016960, Miami 33101.

Family Practice Grand Rounds, Mar. 10, 24, Jacksonville. For information: Mary P. Kellogg, M.D., 655 W. 8th St., Jacksonville 32209.

Problems in Rheumatology, Mar. 11-14, St. Petersburg. For information: Bernard F. Germain, M.D., Box 19, University of South Florida College of Medicine, Tampa 33612.

Symposium on Glaucoma: Patient Evaluation, Surgical and Laser Therapy, Mar. 12, Gainesville. For information: JHM Health Center, Box J-233, Gainesville 32610.

Intensive Care for Neurological Disease and Trauma, Mar. 14-18, Kissimmee, Fla. For information: Gloria Allington, P.O. Box 016960, Miami 33101.

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	300 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	250 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	100 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.


Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



If you're worried
about cancer,
remember this.
Wherever you are,
if you want to talk
to us about cancer,
call us.
We're here to help you.

American Cancer Society
2,000,000 people fighting cancer.

THIS SPACE CONTRIBUTED AS A PUBLIC SERVICE.

13th Annual Topics in Internal Medicine, Mar. 18-20, Gainesville.
For information: JHM Health Center, Box J-233, Gainesville 32610.

St. Moritz 1982 — Advances in Diagnostic Imaging, Mar. 21-28,
St. Moritz, Switzerland. For information: Edward A. Eikman, M.D.,
3100 East Fletcher Ave., Tampa 33612.

Orthopaedics for Family and Emergency Physicians, Mar. 24-27,
Lake Buena Vista, Fla. For information: Allan W. March, M.D.,
JHMC, Box J-222, Gainesville 32610.

**Postgraduate Course on Interesting Topics in Orthopedics —
1982**, Mar. 25-27, Palm Beach Gardens. For information: Michael S.
Zeide, M.D., 2501 N. Flagler Drive, West Palm Beach 33407.

Practice Update in Obstetrics and Gynecology, Mar. 31-Apr. 2,
Kissimmee, Fla. For information: Amelia C. Cruz, M.D., Dept. of
Ob/Gyn, University of Florida College of Medicine, Gainesville 32610.

APRIL

Fifteenth Family Practice Review, Apr. 5-9, Kissimmee, Fla. For
information: University of Florida College of Medicine, Box J-233,
Gainesville 32610.

**Comprehensive Review Course for ECFMG, FLEX and VQE (in
Spanish)**, April 5-July 16, Miami. For information: Rafael Penalver,
M.D., University of Miami, P.O. Box 016960, Miami 33101.

**Spinal Surgery: A Combined Neurosurgery and Orthopedic
Advanced Course**, Apr. 5-9, Miami Beach. For information: Dept. of
Orthopedics and Rehabilitation, University of Miami School of
Medicine, P.O. Box 016960, Miami 33101.

Clinical Management of Coronary Disease and Exercise Testing,
Apr. 16-18, Orlando. For information: Charles E. Aucremann, M.D.,
7300 Demens Dr. South, St. Petersburg 33712.

MAY

Third Annual Advanced Cardiac Life Support for Physicians,
May 7-8, Cedars of Lebanon Health Care Center, Miami. For informa-
tion: Debbie Zayas, 1400 N.W. 12th Ave., Miami 33136.

Master Approach for Cardiovascular Problems, May 29-June 1,
Walt Disney World, Fla. For information: Louis Lemberg, M.D., Dept.
of Cardiology, University of Miami School of Medicine, Box 016960,
Miami 33101.

JUNE

Cardiology for the Practitioner, June 4-11, Mississippi Queen
Steamboat Cruise. For information: Lamar Crevasse, M.D., University
of Florida College of Medicine, Box J-233, Gainesville 32610.

Annual Homecoming in Psychiatry, June 11-12, Miami. For infor-
mation: University of Miami, Dept. of Psychiatry, P.O. Box 016960,
Miami 33101.

18th Annual Resident's Day in Ophthalmology, June 19-21, Key
Biscayne, Florida. For information: Gaby Kressly, Dept. of Ophthal-
mology, University of Miami, P.O. Box 016960, Miami 33101.

UNIVERSITY OF MIAMI
SCHOOL OF MEDICINE

TUTORIAL COURSES OF
INSTRUCTION IN
CORONARY CARE

Director: Louis Lemberg, M.D.
Co-Directors: Kyriacos Pefkaros, M.D.
Robert J. Myerburg, M.D.

SCHEDULE OF COURSES

1981

August 3-8
September 14-19
October 26-31
December 7-12

1982

January 18-23
February 15-20
March 8-13
March 29-April 3
June 14-19

(For more information please call (305) 325-6411 or complete coupon and mail to: M. Enriquez, Division of Cardiology (D-39), University of Miami School of Medicine, Post Office Box 016960, Miami, Florida 33101).

Please send me more information regarding
Tutorial Courses of Instruction in Coronary Care

Name _____

Phone () _____

Address _____

_____ Zip _____



PROFIT FROM OUR EXPERIENCE

For over fifty years, Florida National has invested hundreds of millions of dollars for Employee Benefit Trusts. And our record of performance is impressive.

We specialize in attaining the results that you require from your account in the areas of:

● **PLAN DESIGN** — We provide assistance in designing a plan tailored to your needs.

● **PLAN ADMINISTRATION** — We offer experienced administration through continual communication, assistance with government reporting and compliance, and automated accounting and securities clearing systems.

● **PORTFOLIO MANAGEMENT** — Our portfolio specialists utilize aggressive cash management and design individual portfolios that are compatible with your investment objectives.

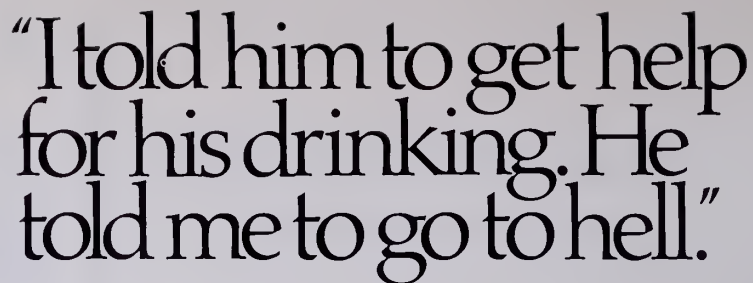
Seek the experience and "know-how" of the Employee Benefit specialists that are dedicated to helping you reach your goals . . . the Florida National Trust People.

PEOPLE WHO KNOW HOW.

**Florida National
Trust Services**

214 Hogan Street
Jacksonville, Florida 32231
Toll Free Telephone #1-800-342-1465, Ext. #5310

Member FDIC



Fenwick Hall has the staff, the facilities and the compassion to treat any stage of alcohol or drug addiction. Our 4 to 6 week specialized program incorporates medical detoxification and counseling with a unique Family Program, comprehensive After Care and the tenets of AA to enhance self-growth and recovery without sacrificing dignity.

**JCAH ACCREDITED. BLUE CROSS/CHAMPUS PROVIDER.
MOST PRIVATE INSURANCE ACCEPTED.**



P.O. Box 688, Johns Island, South Carolina 29455 (803) 559-2461

neonatologist

MARTIN MEMORIAL HOSPITAL, Stuart, Florida, is seeking a Neonatologist to serve as Co-Director of a new Level II Nursery. The hospital is a 310 bed, acute care institution located 40 miles north of the Palm Beachs on the Atlantic Coast. Applicants must be board certified in pediatrics with special interest, training and experience in neonatology. For details contact

Guy N. Cromwell, Executive
Vice President

**martin memorial
hospital**

P.O. Drawer 2396
Stuart, Florida 33495
(305)237-5200

An Equal Opportunity Employer M/F

Index to Volume 68

January-December, 1981

Acute Leukemia Mimicking Acute Appendicitis	108-2
Aerospace Medicine, Central Florida, 1981	813-10
Annual Meeting:	
First House of Delegates	512-7
General Session	518-7
Index to Proceedings	479-7
President's Address, T. Byron Thames, M.D.	509-7
Report of Reference Committee I	532-7
Report of Reference Committee II	538-7
Report of Reference Committee III	544-7
Report of Reference Committee IV	573-7
Report of Reference Committee V	579-7
Second House of Delegates	524-7
Third House of Delegates	569-7
Aplasia, Pure Red Cell, With Thymoma	890-11
Auxiliary:	
Aging: A Positive Process	1000
Auxiliary Respects Time	119-2
Coping With Grief	918-11
Fifteenth Annual Benefit Art Show Winners, 1980-1981	591-7
FMA Auxiliary News Capsules	665-8, 845-10
School Health—A Shared Responsibility	63-1
Citrus, Seafood Sales Aid Impaired Physicians	319-4
Blepharospasm	974
Board of Governors:	
Summary of Board of Governors Meeting, January 17, 1981	94A-2
Summary of Board of Governors Meeting, March 14, 1981	254A-4
Summary FMA Board of Governors Meeting, June 20, 1981	490A-7
Books Received	66-1, 327-4, 393-5, 670-8, 924, 999
Book Reviews	65-1, 326-4, 391-5, 463-6, 669-8, 783-9, 847-10, 923-4, 999
Calcium Channel Blockers:	
Rationale for Clinical Use	883-11
CO ² Laser in Head and Neck Surgery	21-1
Cancer Screening, Colon and Rectal Cancer	501-7
Cholera in South Florida, Case of Shellfish	816-10
Community Mental Health Centers Pro and Con	103-2
Correspondence	1-61, 131-2, 323-4, 662-8, 779-9, 840-10, 1004
Deaths	
Dermoid Cysts of the Mouth	672-8, 937-11
Disseminated Coccidioidomycosis with Respiratory Failure	365-5
Dysphagia and Cricopharyngeal Myotomy	434-6
Echocardiographic Evaluation in Surgically Treated Infective Endocarditis	980
Editorials:	
AMPAC Celebrates its 20th Birthday	875-11
The AMA: The Medical House of Glass	873-11
The Biological Clock and Longevity	247-4
A Christmas Hope for the Future	959
Editorial Policies and Practices	416-6
The First Domino to Fall	961
The FMA/FMF Impaired Physician Program	153-3
Hats Off to the Auxiliary	153-3
Here We Go Again	619-8
The House of Healing	9-1
How Much is Enough?	85-2
Human Experimentation Committee vs. Edward Jenner	346-5
The Journal Comes Full Cycle	695-9
Medicine's Spinoffs Alone Justify Space Programs ..	809-10
Needs for a School of Public Health in the State of Florida	962
Reflections on Book Reviews	416-6
The Routine Autopsy	345-5
Stress, Lifestyle and the Physician	247-4
Wounded Healers	960-1
Encephalopathy Secondary to Abusive Gasoline Inhalation	823-10
Florida Statewide Cancer Data System	361-5
Foreign Bodies in the Stomach and Duodenum	30-1
Gallbladder Disease, Experience With Tc 99m HIDA ...	357-5
Gray Paper	255-4, 810A-10
Gynecological Microsurgery in a Community Hospital .	431-6
Hypertrophic Subaortic Stenosis (Idiopathic), Increased Risk	369-5
Isolated Rupture of Extensor Pollicis Longus Case Report	986
Lipoma, Sacral, and Tethered Cord, Diagnosis by Computed Tomography	499-7
Listeriosis, Congenital	825-10
Lithium: An Overview of Practical Considerations	819-10
Myocardial Infarction, Management of Acute	425-6
Medical News Around the State	59-1, 129-2, 204-3, 387-5, 458-6, 588-7, 664-8, 701-9, 842-10, 917-11
Meetings	67-1, 135-2, 222-3, 330-4, 395-5, 465-6, 593-7, 674-8, 784-9, 852-10, 929-11, 1005
Methodist Hospice Program	293-4
Nongonococcal Urethritis A Clinical Problem of the 80's	965
Notes and News	
Organization:	
Acknowledgement	456-6
Annual Meeting Program Offers 20 Hours of Free CME Credit	303-4
Annual Meeting Scientific Program Offers Something for Everyone	123-2
Concurrent Care—Necessary vs. Unnecessary	47-1
FMA Annual Meeting Program to Schedule Basic Life Support Certification	215-3, 313-4
FMA Board of Governors Meeting, October 7-8, 1981	903-11
FMA Committee on Professional Liability Report ...	908-11
FMA/FMF Impaired Physician Program Gets First Medical Director	46-1

Florida Legislature to Convene Early;	
FMA Legislative FLAMPAC Workshop Planned . . .	839-10
Florida Medical Association, Inc.	
Officers, Councils and Committees 1981-1982	594-7
Gov. Bob Graham Praises FMA Promotion of	
Public Health Programs	205-3
Impaired Physician Intervention Workshop in Miami	
This Month	214-3
Impaired Physician Intervention Workshop in Tampa	
in September	587-7
Impaired Physician Workshop Precedes	
FMA Leadership Conference	46-1
JCAH Receives Kellogg Grant to Develop Hospice	
Accreditation Standards	49-1
JCAH Surveys Set for Early 1981 for	
36 Florida Hospitals	52-1
Medical Malpractice Prevention Seminars Offered	
by Physicians' Reciprocal	209-3
Nine Large Florida Newspapers Visited by FMA	51-1
105th President of FMA, Sanford A. Mullen, M.D. . . .	455-6
Oregon Sex and Marriage Expert to Keynote	
Annual Meeting Program	50-1
Pfizer Dialogue Programs to Carry Out	
Annual Meeting Stress Theme	210-3
Restaurants of the Gold Coast	311-4
Sen. Hatch to Speak at Annual Meeting	301-4
Scientific and Educational Exhibits	314-4
T. Byron Thames, M.D., A Year of Leadership	381-5
"The Process of Aging" is Theme for	
108th FMA Annual Meeting	915-11
Robert E. Windom, M.D. Named to	
HHS Advisory Panel	45-1
Pessaries and Prolapse	895-11
Potassium Supplementation: Comparative Studies in	
Edematous and Nonedematous Patients	37-1
President's Page:	
A Final Message	343-5
Community Service by Physicians	413-6
Florida Doctors and the American	
Medical Association	867-11
A Holiday Message	953
A Tribute to USF College of Medicine	693-9
Community Service by Physicians	413-6
Florida Doctors and the American	
Medical Association	867-11
Interaction With the Legislature	83-2
Medicine and Business	481-7
Medicine and History	613-8
Remembering Those Who Serve	151-3
Stress and Lifestyle	245-4
The United States Space Program	799-10
Voluntary Effort or Government	7-1
Primitive Hypoglossal Artery Associated With Middle	
Cerebral Artery Aneurysm	496-7
Professional Liability Legal Update:	
Cardiopulmonary Resuscitation	19-1
Informed Consent-Prescription of Drugs	811-10
Medical Malpractice Claims—	
Causes and Prevention	159-3
Medical Records	251-4
No Code Orders	487-7
Regulation of Medical Staffs	93-2
Quinsy—Peritonsillar Abscess Revisited	99-2
Scuba Diving Accidents, Emergency Management	491-7
Septal Defect, Interventricular, Resulting From Blunt	
Chest Trauma, Successful Repair	438-6
Splenic Preservation, Rationale and Methods	887-11
Special Articles:	
Adjuvant Chemotherapy of Breast Cancer	43-1
Agent Orange: What's It All About?	991
Bad Hospital PR—The Patient Pays	657-8
Commentaries on the Consensus Conference on	
Coronary Bypass Surgery	833-10
Coronary Artery Bypass Surgery:	
Scientific and Clinical Aspects	827-10
Endoscopy in Upper GI Bleeding	43-1
Excellence in Medicine: A Rewarding Pursuit	655-8
Febrile Seizures	41-1
The FMA Retired Lives Reserve:	
An Innovative Plan to Insure your Future	989
Florida Statewide Health Coordinating Council—	
What Is It?	441-6
Hospital Privileges: Who Should Have Them?	658-8
Membership: It's a Question of Dollars and Sense . .	902-11
NIH Conference to Examine CT Scanning	660-8
Penicillinase—Producing Neisseria Gonorrhoeae in	
Florida	375-5
Physician Extenders in Florida	371-5
Practicing Physicians, Past-Present-Future	443-6
Preventive Medicine—A New Perspective	447-6
Summary of Consensus Development Conference on	
CEA	377-5
Update—FMA-FMF Impaired Physician Program	291-4
The House of Medicine	899-11
The Methodist Hospice Program	293-4
What Became of the Rotating Internship?	837-10
Worker's Compensation Revisited 1980	113-2
Special Issues	
Special Auxiliary Issue	
Auxiliary in Action	163-3
FMA Auxiliary—A Half Century of Progress and	
Accomplishment	166-3
Action in the Counties	169-3
The Auxiliary's Talent Search Program	177-3
Highlights From the Auxiliary Beeper	179-3
Here's a Closer Look at What the Auxiliary is About,	
What it's Doing and Who's Doing it	184-3
Join the PR Team	186-3
Legislation	188-3
How the AMAA Pumps Life into State and County	
Auxiliaries	190-3
Till Death Do Us Part	192-3
The Florida Physician and His Family in Crisis	195-3
Come to the Annual Meeting and	
Bring Your Spouse	200-3
In the Wings	202-3
Historical Issue	
In This Issue	623-8
Prehospital Mobile Emergency Care in Miami,	
Florida—An Historical Commentary	624-8
Pensacola's Early Hospitals	635-8
Florida and the Spanish Flu	644-8
Special Issue: Symposium on Stress	
Is the Medical Marriage Hazardous to Your Health? . .	261-4
The Relaxation Response: Your Inborn Capacity to	
Counteract the Harmful Effects of Stress	265-4
The Prevention of Physician Impairment	268-4
Occupational Stress and Productivity:	
Strategies for Physical and Fiscal Health	274-4

Are Doctors Different? Reflections on the Psychodynamics of Physicians	281-4
System Failure: The Impaired Physician	285-4
Special Issue: University of South Florida College of Medicine	
Introduction	703-9
The Birth of a Medical School—An Act of Creation ..	705-9
The First Ten Years	707-9
The Charter Class	714-9
The Charter Class, A Living Foundation	724-9
The Lady Speaks	727-9
A Student's Perspective	730-9
Admissions	733-9
The Student Body	736-9
Curriculum at the University of South Florida College of Medicine	738-9
Hospital Affiliations	744-9
Residency Training Programs	748-9
Surgical Residency at USF College of Medicine	750-9
Ph.D. Program in Basic Medical Sciences	752-9
The Mace	754-9
The Fulltime Faculty	756-9
The Change of Life at 50	758-9
Medical School Organization	761-9
Clinical (Volunteer) Faculty	762-9
Special Clinical Programs	763-9
Medical Library	768-9
Faculty Research	769-9
Continuing Medical Education	772-9
What of the Future?	775-9
Tay Sachs Screening in Florida Seven Years Experience	24-1
Spinal Cord Injury in South Florida	968
Splenic Preservation, Rationale and Methods	887-11
Worth Repeating	
Best Medical Judgment	919-11
Can Big Government and Medicine Ever Find Happiness Together?	1001
Competition—The New Threat	920-11
Professional Courtesy	921-11
RVS, Specialty Screens, PATCO and Medicine	1002
Authors	
Ackerman, Rony, Homestead	108-2
Acosta-Rua, Gaston J., Jacksonville	496-7
Adams, John E., Gainesville	247-4
Akin, Richard B., Fort Myers	501-7
Alexiou, N. G., Tampa	816-10
Allen, W. Giles, Jacksonville	365-5
Ambrusko, John S., Bradenton	816-10
Aronsohn, Richard S., Jacksonville	345-5
Balis, Gene A., Tampa	499-7
Baroudi, Issa F., Port Charlotte	986
Barry, Patricia, Tampa	727-9
Bartels, Loren J., Tampa	724-9
Bedoya, Ricardo, Lake City	357-5
Benson, Herbert, Boston, Mass	265-4
Binus, Mark H., Gainesville	819-10
Blum, Jeffrey C., Chapel Hill, N.C.	268-4
Bolooki, Hooshang, Miami	438-6
Bouis, Pierre J., Jr., Cocoa Beach	965
Brady, Patrick G., Tampa	327-4
Breen, John F., Tampa	369-5
Buchanan, Paul, Kennedy Space Center	813-10

Burnam, J. Andrew, Miami	110-2
Busard, Mrs. Thomas, Bradenton	177-3
Cassisi, Nicholas J., Gainesville	99-2
Christensen, James A., Tampa	750-9
Cohan, Suzanne, Pensacola	848-10
Coleman, Mrs. Francis C., Tampa	202-3
Coleman, Francis C., Tampa	324-4, 875-11
Collins, Clyde M., Jacksonville	293-4, 454-6, 959
Conn, James K., Tallahassee	85-2, 325-4, 619-8, 919-11
Conti, C. Richard, Gainesville	835-10, 883-11
Cromartie, Robert Samuel, III, Ormond Beach	980
Crowder, Mrs. Ben M., Winter Haven	63-1
Crymes, James E., Miami	30-1
DeBakey, Michael E., Houston, Texas	655-8
Deju, Jorge, Sanford	962
DeRemee, Richard A., Rochester, Minn	837-10
Dlesk, Andrea, Gainesville	391-5
Donegan, Charles, St. Petersburg	899-11
Doty, W. Daniel, Pensacola	980
Drlicka, Albert V., Pensacola	783-9
Earlywine, Garnett R., St. Petersburg	890-11
Eberly, Arthur L., Jr., Lighthouse Point	1002
Eye, Earl H. Jr., Jacksonville	65-1
Farrell, Kenneth L., Fort Lauderdale	392-5
Feinstein, Richard J., Miami	371-5, 780-9
Fenske, Neil A., Tampa	991
Ferguson, Emmet F. Jr., Jacksonville	441-6
Fisher, John J., Jacksonville	431-6
Flowers, Franklin P., Tampa	991
Friedman, Abe W., Pittsburgh, Pa.	980
Gallagher, T. James, Gainesville	491-7
Gilliland, Mrs. C. H. Gainesville	166-3
Goldberg, Myron L., Miami	968
Golloway, Glenn, Tampa	281-4
Goodale, Irene L., Boston, Mass.	265-4
Graham, Mrs. Angus W., Bradenton	186-3
Green, Barth A., Miami	968
Harrell, Henry L., Ocala	920-11
Henderson, Mrs. C. Brooks, Ocala	319-4
Hirschman, Jim C., Miami	624-8
Hoffman, Mitchel, Tampa	965
Houston, William H., Jacksonville	961
Howell, James T., Tallahassee	361-5, 375-5
Huang, S. C., Plant City	825-10
Ingram, James M., Tampa	10-1, 758-9
Isaacs, John H. Jr., Gainesville	99-2
Isley, Joseph K. Jr., Fort Myers	501-7
Jacobson, Lawrence H., Miami Beach	327-4
Jude, James R., Miami	835-10
Kadivar, Hooshang, Fort Pierce	438-6
Karampelas, Dean, Tampa	823-10
Kenyon, Norman M., Miami	783-9
Khuddus, Shaik A., Fort Pierce	438-6
Kitchens, Craig, Gainesville	346-5
Klemme, John W., Tampa	369-5
Klose, Caryl, Miami	968
Klose, K. John, Miami	968
Kullman, George, St. Petersburg	21-1, 434-6
Lacsamana, R. G., Daytona Beach	658-8, 1001
Lemberg, Louis, Miami	425-6
London, Rose, Miami Beach	326-4
Lotz, M., Tampa	816-10
Manry, Willard F., Lake Wales	47-1
Martija, Mrs. Rod, Longwood	179-3, 918-11

Matthews, Joseph G., Orlando	153-3	Safko, Ken R., St. Petersburg	662-10
Mehta, Paulette, Gainesville	108-2	Sammons, J. H., Chicago	902-11
Merimee, Thomas J., Gainesville	37-1	Schiebler, Audrey, Gainesville	848-10
Messina, Anthony M., Tampa	965	Schiffman, Kenneth L., Tampa	730-9
Meyer, William H. Jr., Fort Pierce	438-6	Schulkind, Martin L., Gainesville	447-6
Modell, Jerome H., Gainesville	780-9	Selander, Guy T., Jacksonville	291-4
Monnin, Charles A. Jr., Hialeah	311-4	Sherman, Roger, Tampa	887-11
Morrow, Matthew E., St. Augustine	66-1	Slaughter, Frank G., Jacksonville	960
Mullen, Sanford A., Jacksonville	413-6, 481-7, 613-8, 693-9, 799-10, 867-11, 953, 989	Smith, Donn L., Tampa	703-9
Muniz, Carlos E., Gainesville	819-10	Steele, Robert G., Sarasota	326-4
Murray, Louis C., Orlando	323-4, 381-5	Straight, William M., Miami	623-8, 644-8
Murtagh, F. Reed, Tampa	499-7	Swing, Mrs. Fred P., Port Charlotte	119-2, 163-3
McCormick, William F., Galveston, Texas	496-7	Szentivanyi, Andor, Tampa	705-9
McCollough, Newton C., III, Miami	968	Tabeling, Barbara B., Gainesville	491-7
McIntosh, Henry D., Lakeland	833-10	Tignor, Mrs. Milton, North Palm Beach	200-3
McNicholas, Anthony J. III, Jacksonville	19-1, 93-2, 251-4, 487-7, 811-10	Thames, T. Byron, Orlando	7-1, 83-2, 151-3 245-4, 343-5, 913-11
Nagel, Eugene L., Winter Haven	624-8	Thrasher, John, Jacksonville	19-1, 93-2, 251-4, 487-7, 811-10
Nunn, Daniel B., Jacksonville	153-2, 416-6	Tocci, Paul, Miami	24-1
Nunn, Mrs. Daniel B., Jacksonville	190-3	Trainer, Joseph B., Portland, Ore.	261-4
Olin, Fred H., Bexar County, Texas	921-11	Trobe, Jonathan D., Gainesville	974
Olsen, Gerald N., Jacksonville	365-5	Troiano, Anthony G., Gainesville	819-10
Palin, Douglas G.,	361-5	Van Mierop, L.H.S., Gainesville	392-5
Panush, Richard S., Gainesville	391-5	Vickers, F. Norman, Pensacola	416-6, 463-6, 657-8
Pedrero, Edward Jr., Tampa	9-1, 247-4, 873-11	Vickers, Mrs. F. Norman, Pensacola	192-3, 635-8 668-8, 847-10, 923-11
Penrod, Kenneth E., Tallahassee	443-6	Von Thron, Joseph C., Cocoa Beach	809-10
Perillo, Louis J., Gainesville	819-10	Weigand, Mrs. Frederick J., Deltona	195-3
Pfifferling, John-Henry, Chapel Hill, N.C.	268-4	Whisman, Pattye A., Columbus, Ohio	991
Phillips, Philip B., Pensacola	103-2	White, Mrs. James G., Ormond Beach	188-3
Prockop, Leon D., Tampa	823-10	White, Mrs. L. G., Fort Lauderdale	169-3
Rashid, Ahmad, Fort Pierce	438-6	Witzel, Everet W., Singapore	285-4
Richards, James F., Orlando	113-2	Wood, William, Chapel Hill, N.C.	268-4
Rodenberg, Thomas A., Miami	895-11	Wroten, Jack E., Jacksonville	375-5
Rodgers, Bradley M., Gainesville	327-4	Yeller, R. Michael, Tallahassee	361-5
Rodrick, G. E., Tampa	816-10	Yergin, Bruce M., Jacksonville	365-5
Rosen, Arthur H., Jacksonville	274-4		
Rubio, Fernando A., St. Petersburg	890-11		

**Medical
Decorators**

**NEW OR EXISTING SPACE
PROFESSIONALS WORKING
AROUND YOUR SCHEDULE**

**(305) 772-0090
By Appointment**

**CARY MARTIN
5055 N.E. 13 Ave.
Fort Lauderdale, Fla. 33334**

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent \$250 per month. Competent laboratory and x-ray departments with income based on use. Book-keeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

PHYSICIANS WANTED! Non-clinical disability evaluation, medical consultation for Social Security. Fulltime 40 hour work week. Knowledge of electrocardiographic interpretation desirable. Write or call Dr. George Davis, State Medical Consultant, 3438 Lawton Road, Suite 127, Orlando, Florida 32803. Phone (305) 896-4691.

EMERGENCY MEDICINE: Clinical and Directorship positions available in moderate volume emergency department located in Brooksville. Excellent income, flexible scheduling without on-call duty, and paid malpractice insurance. For details, send credentials in confidence to Susan Haberman, 1111 N. Westshore Blvd., Suite 211, Tampa, Florida 33607; or call collect (813) 870-2356.

WANTED: NON-INVASIVE CARDIOLOGIST to join well established high caliber internal medicine group in Florida. Private practice affiliated with excellent hospital with stress, nuclear and echo. Lucrative. Delightful location. Contact: C-1068, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST — CARDIOLOGIST: Three man practice seeks badly needed associate with immediate availability possible. Excellent opportunity in well established Internal Medicine, non-invasive Cardiology practice in Coral Gables, Florida. Reply C-1036, P.O. Box 2411, Jacksonville, Florida 32203.

TAMPA BAY AREA, Family Practice, part or fulltime, E. House, M.D., (904) 796-9425, Brooksville; you choose your workload.

FAMILY PHYSICIAN needed for solo or group type practice. Fee for services and guaranteed referrals. Brand new and well equipped office building. Located on one of Florida's finest Gulf and sun coast communities. Center for cultural, educational and recreational resources. Good opportunity for right person. For more information contact: Post Office Box 834, Bradenton, Florida 33506.

PHYSICIANS WANTED to form medical-dental complex, either condominium or individual buildings. Special interest rates well below prime rate may be available for total financing. Beautiful Central Florida location. Write: Dr. M. Max Weaver, One Doctors Lane, Lake Wales, Florida 33853 or call (813) 676-8536.

PULMONARY INTERNIST/Board certified or Board eligible. Location: Fast growing area of southeast Florida. Expanding group of physicians seeks association with Board certified or Board eligible pulmonary internist. Please send curriculum vitae to C-1072, Post Office Box 2411, Jacksonville, Florida 32203.

FLORIDA — Family Physicians for rural or metropolitan emergency departments. Full or parttime. Immediate openings. Florida license required. Contact Dr. Julius Garner or Dora Harrison, Suite 100, 238 Westmonte Road, Altamonte Springs, Florida 32701. Phone (305) 788-0786.

FP NEEDED to associate with two other FPs in office in north Palm Beach County, (Jupiter-Tequesta area). Also space for ophthalmologist, dermatologist or surgeon. Coverage and assistance available. Two open staff hospitals nearby for qualified M.D.s. (305) 746-2033 or (305) 747-0279.

PRIMARY CARE: Family Practitioners, Internists and Pediatricians are being sought for staff positions with INA Healthplan. Excellent opportunity to grow with this prepaid health plan in the Tampa Bay area. Come enjoy the living on Florida's Suncoast. Send C.V. to: Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516.

PEDIATRICIAN to join solo Boarded Pediatrician in fast-growing west central Florida area, on or after July 1982. Contact David W. Powers, M.D., 415 North Central Avenue, Inverness, Florida 32650. (904) 726-8860.

PHYSICIANS — JACKSONVILLE, FLORIDA (Duval County Health Department). Public Health duties include responsibility for and performance in screening programs and primary care clinics. 40 hour week, excellent salary and benefits (sick and annual leave, hospitalization and life insurance, Social Security and full funded retirement). Eligibility for or Florida licensure required. Contact S. D. Rowley, M.D., Director, 515 West 6th Street, Jacksonville, Florida 32206. (904) 633-2280.

FAMILY MEDICINE OR GENERAL INTERNAL MEDICINE: New multi-specialty clinic with 10 suites in rapidly growing rural county. Five physicians with active practices looking for five additional partners. Population growth exceeds 15% annually, demographically skewed toward retirement age group. Two partners needed to supplement existing General Practitioners and absorb excess patient load, share calls and coverage. Clinic will have an evening minor emergency clinic and an ambulatory surgical facility, located 45 miles north of Tampa in Brooksville, Florida. Convenient to excellent fishing, hunting and beaches. 60 miles northwest of Orlando Disney World. Call Bill Cosner at (813) 879-1652 for further information.

INTERNIST seeking to share well equipped 2,000 sq. ft. office with another specialist. Well located in a professional building in Coral Gables, Florida. Contact Dr. Veliz, 475 Biltmore Way, Suite 206, Coral Gables, Florida 33134. (305) 445-1115.

FAMILY PRACTITIONER: Illness forces immediate association — eventual sale of busy Miami Beach practice established for 16 years. Large gross. Prefer Board certified or Board eligible. Please send CV to Robert LaVey, M.D., 414-71st Street, Miami Beach 33141. (305) 864-8303.

IMMEDIATE OPENINGS FOR ONE FAMILY PRACTITIONER AND ONE INTERNIST: Board certified or eligible for multispecialty association. West coast of Florida, 30 miles north of Clearwater and Tampa. Minimum guarantee with incentive first year, partnership opportunity after first year. Send CV to Michael T. Gossman, Community Health Center, 1150 Plaza Drive, New Port Richey, Florida 33553.

EMERGENCY ROOM PHYSICIAN, SOUTH GEORGIA: Physician owned group needs additional full time emergency physician. Contact with medium size hospital; good community; excellent place to rear children; salary negotiable, and early partnership.

PRIMARY CARE PHYSICIANS needed for excellent practices in over 20 Florida communities. Solo or partnership practices available. Assistance available from some communities. For complete information, contact the State of Florida Health Manpower Recruitment/Placement Program, 2425 Torreya Drive, Tallahassee, Florida 32303. (904) 386-3191. There is no charge for our services under funding provided by the State of Florida.

OB-GYN DIRECTOR: Opening for Director of Residency Training Program in Obstetrics and Gynecology with the Pensacola Educational Program, Pensacola, Florida, for board certified physician. Total program of 60 residents in six different residencies (10 residents in 4-year Ob-Gyn program) associated with four different hospitals in community-based educational program. Salary competitive with excellent fringe benefits of paid vacation, liability insurance, health/disability insurance, paid educational and professional trips. Program affiliation with several large medical schools. Gulf coast living at its best, and health care in immediate area of over ¼ million. If interested in teaching and patient care, call collect: Dr. R. D. Nauman, Director of Medical Education (904) 477-4956 or send CV to Director of Medical Education, Pensacola Educational Program, 5149 North 9th Avenue, #307, Pensacola, Florida 32504.

CARDIOLOGIST INTERNIST/ Board certified or Board eligible. Clinical cardiologist to join in top notch internal medicine group in beautiful area. Private practice with hospital affiliation. Stress, nuclear and Echo available. Contact C-1078, P.O. Box 2411, Jacksonville, Florida 32203.

Situations Wanted

UROLOGIST, 31, American Graduate, Florida license, Board Eligible, excellent training at large New York City Medical Center. Desires group practice or partnership in South Florida. Phone: (212) 289-7235, evenings.

EXPERIENCED INTERNIST / RADIOLOGIST seeks full or parttime salaried position with hospital or industry involving administration and/or clinical duties. Age 46. Available December 1981. Call Dr. R. Kline (305) 532-9615.

UROLOGIST, trained at major New York medical center with one year of pediatric urology fellowship at Toronto. Florida license, available immediately. Call (212) 282-3250.

UROLOGIST AND ANESTHESIOLOGIST, husband and wife, excellent university qualifications, are looking for opportunities beginning July 1982 in a semi-urban community. Solo or partnership offers welcome. Reply to C-1070, Post Office Box 2411, Jacksonville, Florida 32203.

UNIVERSITY TRAINED GENERAL SURGEON currently doing a fellowship in vascular surgery seeks position. Contact Dr. Ruben Delgado, Spring Ridge M-26, Whitehall, Pennsylvania 18052. Available August 1982.

UROLOGIST, FLORIDA PHYSICIAN, 10 years private practice, desires to relocate. Skilled in microsurgery, infertility and general urological surgery. Please reply C-1074, P.O. Box 2411, Jacksonville, Florida 32203.

RADIOLOGIST — ABR certified, University trained in diagnosis. Fellowship in C.T. and ultrasound. Fellowship in angio., and interventional radiology. Seeks relocation in Florida. Available July 1982. Contact L.S. Chaise, M.D., 12204 Delaire Landing Rd., Philadelphia, Pa. 19114. (215) 632-1774, evenings.

FOREIGN MEDICAL GRADUATE, non-licensed, good in English, desires position as Physician's Assistant or House Physician. Contact Ravindran, M.D., 3566 San Remo Terrace, Sarasota, Florida 33579. (813) 953-5408.

SURGEON, GENERAL AND VASCULAR with 8 years experience in endoscopy, urologic and gynecologic surgery and one year of cardiovascular fellowship under Dr. D.A. Cooley. Would consider any situation. Call (713) 781-3761.

OPHTHALMOLOGIST: Experienced, 44-years old, board certified seeks position in established practice as general medical ophthalmologist with surgery option. All locations considered. Write C-1077, P.O. Box 2411, Jacksonville, Florida 32203.

Practices Available

ACTIVE GENERAL PRACTICE established for 11 years, for sale due to retirement. Well-equipped office, located close to Coral Reef General Hospital, Miami, Florida, will be available December 1981. Reasonable terms. Contact George J. Fiala, M.D., 9875 East Fern Street, Miami, Florida 33157. Telephone (305) 238-8561.

FAMILY PRACTICE FOR SALE: Income in six figures. Well established. 19 years solo practice. Entering new field. Available immediately but will stay to introduce. Office fully equipped, located in Tampa, Florida. Five minutes from all medical centers and University of South Florida College of Medicine. Write P.O. Box 9114, Tampa 33604.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

LAGO VISTA EXECUTIVE CENTER, 8019 N. Himes Avenue, Suite 300, Tampa, Florida 33614. 1,500 square feet, suitable for doctor. Quiet, pleasant atmosphere, overlooking landscaped lake. Convenient location. (813) 933-5100.

CONDOMINIUM for rent St. Thomas U.S.V.I. on the Caribbean, two bedrooms, two bathrooms, three pools, free tennis, reduced airfares. List of meetings available. Call Dr. Blondy collect at (313) 478-2739.

CENTRAL FLORIDA — Ideal for group practice — three or more physicians. Colonial-type office building (approximately 4,000 square feet) with ample parking. All on four lots (33 x 133 each). Fully equipped including lab, x-ray and minor surgery. Located two blocks from Waterman Hospital, a fully accredited 150 bed general hospital with open staff for qualified M.D.s or D.O.s. Price quote on request. Terms negotiable. Contact Dr. Louis R. Bowen, Box 69, Eustis, Florida 32726. (904) 357-4101, (904) 357-3756.

VAIL CONDO — two bedrooms, kitchen, living room, fireplace, beautiful view. \$570/week. Available Christmas and high season. Ralph Bloch, M.D., 9950 W. 80th Avenue, Arvada, Colorado 80005. (303) 425-0961 or 399-9076.

DOCTOR RETIRING: Modern building on attractive corner with shade trees and paved parking. Immediate access to I-275 and minutes to major medical centers in St. Petersburg. On main East/West thoroughfare. 1,200 sq. ft. building featuring reception area, business office, consultation room, three examination rooms, intercom throughout, phones in all rooms, 3½ ton air conditioner, oil heat, mahogany panelling. **GOOD TERMS.** \$92,500. Call R. O. Curry, Realtor/Associate for additional details. After hours (813) 896-0932.

FOR SALE: Sale and/or Lease — Fantastic opportunity for family doctor. Newly remodeled doctors' building. Five examining rooms, one regular lab, one large laboratory, receptionist office, sick room, waiting room, and stock room. More than 2,000 square feet. Beautiful. Located in a peaceful north Georgia community. Diversified industry, Watkins Memorial Hospital and Nursing Home, affiliate of Georgia Baptist Medical Center-Atlanta, located in community. Ideal place to rear children. A real bargain — \$500 rent per month. Need to see to believe. County population 11,126. Contact Ellijay Real Estate Co., Starnes Bldg., Ellijay, Ga. 30540. Call (404) 635-2226; 635-5671; 635-4632.

FOR SALE: North Georgia farm, near Ellijay, 192 acres, 75 acres cleared. Half mile on river with several streams. Old farm house and barns. Contact G. H. Arnold, M.D., 5517-17th Street West, Palmetto, Florida 33561. Phone evenings (813) 722-9510.

MEDICAL OFFICE FOR LEASE: Modern one story masonry building in desirable mid St. Petersburg located across from Disston Plaza Shopping Center, 1,263 sq. ft., carpeted, central heat and air, large reception room, eight additional rooms all with plumbing connections. Two restrooms. Large telephone circuit board for multiple lines. Easy access from parking lot, and in and out of building, no stairs to negotiate. Call Wray Shockley, Broker/Salesman. After hours (813) 522-4743.

SUITE FOR RENT: Centrally located in Lincourt Medical Center. 1,050 sq. ft. of office space. Family practice, Internist or subspecialist. Write or call Lincourt Medical Center, 501 S. Lincoln Avenue, Clearwater, Florida 33516. (813) 446-3851.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Co., 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

CONTEMPORARY PAINTINGS and works on paper for private or corporate collectors. Fine prints by major artists. Special exhibitions October-May. Hodgell Hartman Gallery, 48 South Palm Avenue, Sarasota, Florida 33577. (813) 955-4785.

Equipment

WE BUY, SELL, LEASE new and used medical instrumentation — EKG's, Laboratory, Holters, Scanners, Stress Test, Echocardiographs, etc. Contact: New Life Systems, Inc., Edgar Bentolila, P.O. Box 8767, Coral Springs, Florida 33065. Phone (305) 753-9961.

OFFICE FOR SALE OR RENT: Orthopedic, two man office, approximately 3,000 sq. ft., ideally situated with ample parking. Industrial city of Hialeah. Equipped with x-ray, physiotherapy, nine examining rooms, etc. Would also make a fine emergency center or industrial clinic. Call Keyes (305) 666-5831, Mr. Riley.

WHEELCHAIR, STRETCHERS with wheels and sides, Instruments, I.V. Stands, Carts, More. All one year new and mint. Best Offer. Dr. S. Rosen (305) 475-8423 Ft. Lauderdale.

MEDICAL EQUIPMENT FOR SALE: Keleket x-ray, Pako Processor, Physiotherapy equipment (traction, U.S., E.S.) Examining tables, IBM memory typewriter and other office equipment. Call Dottie (305) 666-3530 after 6 p.m.

Services

DOCTOR, WE KNOW YOUR BUSINESS. With 27 years experience as a Hospital Administrator, Bill Bishop, F.A.C.H.A., understands your needs! He can help you find qualified candidates for that hard to fill position of Office Manager, or Clinic Manager. Bill Bishop and Associates, Inc., Health Care Executive Search Consultants, 1045 Riverside Avenue, Jacksonville, Florida 32204, (904) 354-1050.

Miscellaneous

32' ENDEAVOR SAILBOAT (1980) — Fully equipped plus many extras — RDF, VHF, CB, auto pilot and five man Avon dinghy, etc. Priced at 20% below replacement. Physician owned and maintained. Financing available to right person. \$46,000. Call (904) 763-4838 or (812) 853-3847.

Classified advertising rates are \$10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

Jack Sager is a maintenance man with the NYC Housing Authority. He's mentally retarded.

President's Committee on Employment of the Handicapped Washington, D.C. 20210

1981. The International Year of Disabled Persons.

Advertisers

Boots Pharmaceuticals		Eli Lilly & Company	
Rufen	1010a	Ceclor	955
Ru-Tuss	962a		
Brown Pharmaceuticals		Cary Martin	
Cerebro-Nicin	1006	Decorating	1013
Lipo-Nicin	1007		
Burroughs Wellcome		Martin Memorial	
Zyloprim	954	Hospital	
		Service	1010
Convention Press			
Service	956	National Medical	
		Enterprises	
Fenwick Hall		Service	950
Service	1010		
Florida Medical Center		Roche Laboratories	
Meeting	951	Bactrim	1019
		Valium	948
Florida National Banks			
Service	1009	University of Miami	
		Meetings	988, 1009
Florida Physician			
Insurance Reciprocal		Wetzel	
Service	946	Service	952
Geriatric Pharmaceutical		Willingway Hospital	
Menic	958	Service	963
Hospital Corporation		Wyeth Laboratories	
of America		Clyclapen-W	957
Recruitment	951	Equagesic	962b
		Wygesic	962b

Florida Medical Association Officers and Council Chairmen

Officers

Sanford A. Mullen, M.D., Jacksonville, President
Robert E. Windom, M.D., Sarasota, President-Elect
Gerold L. Schiebler, M.D., Gainesville, Vice President
Luis M. Perez, M.D., Sanford, Secretary
J. Russell Forlaw, M.D., Boynton Beach, Treasurer
T. Byron Thames, M.D., Orlando, Immediate Past-President
James B. Perry, M.D., Ft. Lauderdale, Speaker of the House
Franklin B. McKechnie, M.D., Winter Park, Vice Speaker
W. Harold Parham, D.H.A., Jacksonville, Executive Vice President

Chairmen

James A. Winslow Jr., M.D., Tampa, Judicial Council
Louis C. Murray, M.D., Orlando, Legislation
Charles P. Hayes, M.D., Jacksonville, Health Care Financing
Joseph T. Ostroski, M.D., Miami, Medical Services
Yank D. Coble Jr., M.D., Jacksonville, Scientific Activities
Arthur L. Eberly, M.D., Lighthouse Point, Specialty Medicine

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

This Book is due on the last date stamped below. No further preliminary notice will be sent. Requests for renewals must be made on or before the date of expiration.

DUE

DUE

APR 27 1983

MAR 14 1984

A fine of one dollar will be charged for each week or fraction of a week the book is retained without the Library's authorization.

